STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345296	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Margate Health and Rehab Center	**540 Waugh Street , Jefferson, North Carolina, 28640**

(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 02/08/26 through 02/11/26. Additional information was gathered offsite on 02/13/26, therefore the exit date was changed to 02/13/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1E2FD1-H1.	E0000		02/20/2026
F0000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 02/08/26 through 02/11/26. Additional information was gathered offsite on 02/13/26, therefore, the exit date was changed to 02/13/26. The following intakes were investigated: 2668496, 2706337, 2743727, and 2717793. 11 of 11 complaint allegations did not result in deficiency. See Event ID #1E2FD1-H1.	F0000		02/20/2026
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 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. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews and staff, resident, manufacturer customer service representative, Pharmacy Manager and Nurse Practitioner interviews, the facility failed to protect a resident's right to be free from misappropriation of medication. This failure occurred for 1 of 1 resident reviewed for misappropriation. The findings included:	F0602	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 12/12/25 Resident #1 did not receive the scheduled Mounjaro dose due to the pen devices being found unlocked, depressed, and empty. Upon discovery, the physician was notified, and a replacement dose was obtained from the pharmacy to ensure continuation of prescribed treatment. The resident was assessed for any adverse effects related to the missed dose, and no negative outcomes were identified. On 12/12/25 the Administrator initiated an immediate investigation regarding the condition of the injection pens. The dispensing pharmacy was contacted, and replacement medication was provided and administered on 12/13/25. On 2/12/26 the Director of Regulatory Compliance provided education to the Administrator and the Regional Clinical Manager on the definition of misappropriation per the federal regulations: as defined at §483.5, means "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the	02/20/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345296	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/13/2026

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F0602 SS = D	Continued from page 1 Resident #24 was admitted to the facility on 07/24/23 with diagnoses that included diabetes mellitus. Review of the quarterly Minimum Data Set assessment dated 01/18/26 revealed Resident #24 was cognitively intact and had a diagnosis of diabetes mellitus. Review of Resident #24's physician orders revealed an order dated 09/11/25 for tirzepatide (Monjaro) 5 milligrams (mg) per 0.5 milliliters (ml) administer one syringe subcutaneously once a day on Friday for Type 2 Diabetes Mellitus. Review of a pharmacy delivery sheet dated 12/12/25 and signed by Nurse #4 at 10:00 PM indicated 2 ml of tirzepatide (which equals 4 injections) were delivered from the pharmacy for Resident #24. An interview was conducted with Nurse #4 on 02/11/26 at 12:16 PM who confirmed that she worked on the night of 12/12/25 and signed the pharmacy delivery sheet for Resident #24's tirzepatide pens. The Nurse stated the pens were delivered four in a pack and she put them in the locked box in the refrigerator as the facility treated the tirzepatide pens like the narcotics. The Nurse reported she looked at the pens closely to make sure they had medication in them before she locked them up. Nurse #4 reported that she did not know what happened to Resident #24's two tirzepatide pens that were discovered empty. Review of a pharmacy patient information insurance sheet dated 12/12/25 indicated 2 ml of tirzepatide (4 injections) were charged to Resident #24's insurance. Review of Resident #24's physician orders dated 12/13/25 revealed a verbal order given by the Nurse Practitioner on 12/13/25 at 11:00 AM for tirzepatide 5 mg/0.5 ml administer one syringe subcutaneously one time on 12/13/25. Review of Resident #24's Medication Administrator Record (MAR) for December 2025 revealed there was no documentation that Resident #24 received the tirzepatide injection on 12/12/25 by Nurse #1. There was documentation that the tirzepatide injection 5 mg/0.5 ml was given on 12/05/25 by Nurse #2, 12/13/25 by Nurse #2 and 12/19/25 by Nurse #5. An interview was conducted with Resident #24 on 02/08/26 at 12:17 PM. The Resident explained that about a month or so ago (12/12/25) a nurse (Nurse #1) went to administer Resident #24 her weekly "Mounjaro" (tirzepatide) injection, but the syringe was empty. The	F0602	Continued from page 1 resident's consent." Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 2/12/26 an audit was conducted by the Interim Director of Nursing (DON) and Unit Managers of all residents currently receiving injectable pen medications to verify proper storage, intact medication supply, and correct device condition. This audit included checking for evidence of pre-activation, tampering, or improper storage. Additionally, a review of medication administration practices for the past 30 days was completed to identify any other potential irregularities related to injectable medications. No additional concerns were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 2/12/26 the Director of Regulatory Compliance provided education to the Administrator, Interim DON, and Unit managers. On 2/12/26 the Administrator, Interim DON and Unit Managers provided the above education to all staff on the following systemic changes: Re-education of all staff (licensed nurses, medication aides, and department heads) on the Abuse Prevention Policy, including definitions of abuse, neglect, exploitation, and misappropriation, and required reporting timeframes (immediate reporting to the Administrator/DON and to the State Agency as required). Report any possible abuse, neglect, exploitation, and misappropriation to the Administrator or DON immediately to determine if abuse reporting criteria are triggered. Incorporation of abuse reporting competency into new employee orientation and annual mandatory in-service training. The Interim DON will be responsible for ensuring all staff receive education before working their next or first shift. On 2/12/26 the Administrator, Interim DON and Unit Managers provided the above education to all licensed nursing staff on the following systemic changes:	

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F0602 SS = D	Continued from page 2 Resident continued to explain that the Nurse got another syringe from the refrigerator and that syringe was empty as well. The Resident stated she took the shots for her diabetes, and it helped her to lose weight. She continued to explain that she did get her weekly injection of “Mounjaro”, but it was two or three days late because they had to get it from the pharmacy. She reported that in the past (she could not remember when) she has had to wait for her “Mounjaro” shot to be delivered from the pharmacy which made getting the injection a day or so late, but she has never had the nurses attempt to give her the injection and the syringe be empty before that day (12/12/25). During an interview with Nurse #1 on 02/10/26 at 9:31 AM the Nurse explained that she worked on first shift on 12/12/25 and went to administer the tirzepatide to Resident #24 using the pen she got from the refrigerator. She stated she tried to unlock the pen, but it was already unlocked and the purple cap was depressed. The pen was empty. She stated she informed the Wound Nurse and the Unit Manager, and they went to the medication room refrigerator, and discovered the other tirzepatide pen was the same way, it was empty. Nurse #1 continued to explain that she told Resident #24 that the pens were empty and they would get more medication from the pharmacy and she would get the injection the next day. The Nurse reported that she did not know what happened to the pens or why they would be empty. An interview was conducted at 3:50 PM on 02/09/26 with the Wound Nurse who explained that on 12/12/25 Nurse #1 approached her and asked her to look at the tirzepatide pen that belonged to Resident #24. She stated that Nurse #1 attempted to administer the medication to Resident #24 and could not get the medication to inject. After further inspection it was discovered, the pen had already been used because the purple cap was depressed and there was no medication in the pen. The Wound Nurse stated they went to report their finding to the Unit Manager and all three of them went to the medication room refrigerator where the tirzepatide pens were kept and discovered that both remaining pens were empty. The Wound Nurse reported she did not know why the two tirzepatide pens would be empty. An interview was conducted on 02/09/26 at 3:08 PM with the Unit Manager (UM) who was the acting Director of Nursing on 12/12/25. The UM explained that Resident #24 received weekly injections of tirzepatide on Fridays and on the morning of 12/12/25 around 8:00 AM, Nurse #1 went to administer the tirzepatide injection but could not get the lock mechanism on the syringe to unlock to	F0602	Continued from page 2 Proper preparation, activation, administration, and storage of injectable pen devices, with return demonstration for competency validation. Reinforcement of policy requiring immediate reporting of medication discrepancies or irregularities to the Unit Manager and DON. The DON will report to the Administrator. Implementation of a verification process upon receipt of injectable pen medications from the pharmacy to ensure devices are sealed, locked, and intact prior to storage. Incorporation of injectable pen device handling into new nurse orientation and annual medication administration competency reviews. Current nursing staff and new nursing staff will not be allowed to work until education has been completed. The Interim DON will be responsible for ensuring education was completed. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The Administrator or designee will audit all incident reports, medication variances, and grievance reports weekly for four (4) weeks to ensure appropriate abuse policy review and reporting determinations are completed. Thereafter, audits will be conducted monthly for two (2) additional months. The Director of Nursing or designee will conduct weekly audits of injectable pen medications for four (4) weeks to ensure proper storage and intact condition. Thereafter, audits will be conducted monthly for two (2) additional months. The Administrator will be responsible for taking audit findings to the Quality Assurance and Performance Improvement (QAPI) Committee meetings to evaluate compliance trends and determine if further corrective action is necessary. If issues are identified, additional education and monitoring will be implemented. Date of compliance is 2/20/26	

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F0602 SS = D	Continued from page 3 inject the medication. Nurse #1 asked the Wound Nurse to assist her and the Wound Nurse discovered that the syringe had already been activated. The two nurses reported what they found to the Unit Manager who went to the medication room refrigerator to investigate the remaining tirzepatide syringe and discovered that the remaining syringe had been activated as well and both syringes were empty. She stated she determined that the syringes were empty by comparing them to another resident's tirzepatide prefilled syringe and the other resident's syringe did not have the purple cap depressed. The UM explained that after the medication had been injected the purple cap remained depressed which indicated the syringe was empty. The UM continued to explain that she reported the issue to the Administrator, the Regional Clinical Manager and informed the Nurse Practitioner (NP) of the issue, who gave her a verbal order to hold the medication for 12/12/25 until it was obtained from the pharmacy on 12/13/25. The UM reported that she called the pharmacy and discussed the issue with someone (she could not remember who) and reported that there were two syringes left and both syringes looked as if they were empty, but she could not determine why they were empty but Resident #24 needed her injections. She stated the pharmacy told her that they could send the medication with a new order. The UM stated she thought the facility paid for the medication. The UM stated that the NP also gave a verbal order to Nurse #2 on 12/13/25 to give the tirzepatide on 12/13/25 and the medication was given on 12/13/25 by Nurse #2. The Unit Manager stated she did not think about misappropriation of medication because she was new to the position and the only thing on her mind was what she could do to prevent it from happening again. Interviews were conducted with Nurse #2 on 02/08/26 at 12:30 PM and 02/11/26 at 9:30 AM. The Nurse explained that she worked first shift on 12/13/25 and received a verbal order from the Nurse Practitioner to administer tirzepatide 5 mg per 0.5 ml subcutaneously to Resident #24. The Nurse stated she gave it at 11:37 AM on 12/13/25. The Nurse reported that she gave Resident #24 the tirzepatide on 12/05/25 and did not encounter an empty pen when administering the injection. Nurse #2 stated she did not know what happened to the two tirzepatide pens that belonged to Resident #24. Observations were made of the two tirzepatide pens on 02/09/26 at 3:08 PM and 02/11/26 at 11:25 AM along with the Unit Manager. The pens appeared to be empty, the purple caps were depressed, and the plungers were visible, indicating the medication had been injected or expressed from the pen.	F0602		

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F0602 SS = D	Continued from page 4 On 02/10/26 at 9:53 AM and 02/11/26 at 1:23 PM interviews were conducted with the Pharmacy Manager who explained that on 12/12/25 they received a call from the Unit Manager who stated the last two tirzepatide pens belonging to Resident #24 were empty and they needed a refill. The Pharmacy Manager told the Unit Manager that the pharmacy would need an order before the pharmacy could refill the medication. Soon after that the Nurse Practitioner called the pharmacy (12/12/25) and gave them an order for a refill of the tirzepatide for Resident #24. The Pharmacy Manager explained that the Resident's insurance paid for the medication which was $285.79 per pen. She stated the insurance would occasionally refill a prescription early but not always, but in this case they did. She stated if the insurance company did not agree to pay for the early refill, then the facility would have had to pay for it. The Pharmacy Manager stated they received the tirzepatide injections in a box from the manufacturer, and it was possible for them to be damaged or empty, but the pharmacy would discover any damage before they sent them to the facilities because they had to label and package each pen. The Pharmacy Manager could not provide any specific details about damaged or empty pens. She stated she would expect the facility to report damaged or empty insulin pens to the pharmacy as soon as possible. An interview was conducted with Nurse #3 on 02/10/26 at 10:12 AM. The Nurse stated she received Resident #24's tirzepatide pens from the pharmacy on the night of 11/21/25 and put the pens in the refrigerator as the normal procedure. She stated she usually did not inspect the pens to determine whether they were full, but she did not after 12/12/25 because they treated the pens like narcotics and locked them in the refrigerator. Nurse #3 stated she did not know why the two tirzepatide pens were empty on 12/12/25. During an interview with Nurse #5 on 02/11/26 at 11:00 AM the Nurse reported she gave Resident #24 her tirzepatide injection on 12/19/25. She stated she did not know what happened to the two tirzepatide pens or why they would be empty on 12/12/25. On 02/11/26 at 12:00 PM an interview was conducted with a representative from the tirzepatide manufacturer who explained that the tirzepatide pens were supplied to the pharmacy in a box of four pens and it was possible that the pens could leak but the pharmacy would notice they leaked when repacking the pens. An interview was conducted with the Nurse Practitioner	F0602		

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F0602 SS = D	Continued from page 5 on 02/10/26 at 3:35 PM who explained that the Unit Manager reported to him on 12/12/25 that Nurse #1 went to give Resident #24 her tirzepatide and the pen was empty then when they went to use the other pen, they discovered that the other pen was empty as well. The Nurse Practitioner stated he called the pharmacy and gave them an order to refill the prescription, and they sent the medication the next day and Resident #24 received the medication. The Nurse Practitioner stated the facility was going to investigate the empty pens, but he did not know the outcome. On 02/11/26 at 9:00 AM an interview was conducted with the Regional Clinical Manager who explained that the Unit Manager called her on 12/12/25 when the empty tirzepatide pens were discovered. She reported that the Unit Manager did not know how the pens were emptied but because they were expensive and highly sought after she wanted to lock them up and treat them like narcotics, which she thought was a good idea because they do that in other buildings. The Regional Clinical Manager stated she thought about why the tirzepatide pens were empty and concluded it could be human error or misappropriation but more so human error. On 02/11/26 at 3:19 PM an interview was conducted with the Administrator who explained that she was notified by phone on 12/12/25 by the Unit Manager about the empty tirzepatide pens but she did not go into detail. The Unit Manager was going to investigate the issue and notify the Nurse Practitioner to get an order for more medication and then notify the Regional Clinical Manager. The Administrator stated she should have been more diligent in the investigation to determine how the pens were emptied but she did not. The Administrator stated she did not think about misappropriation of medications because if she did, she would have reported it.	F0602		
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and	F0607	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 was identified as potentially affected when two Mounjaro injection pens were found unlocked, depressed, and empty at the time of attempted administration. The dose was withheld, the physician was notified, and replacement medication was obtained from the pharmacy. The resident was assessed for adverse effects related to the missed dose, and no negative outcomes were identified. Although the investigation revealed no evidence of abuse, neglect, exploitation, or misappropriation, the	02/20/2026

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F0607 SS = D	Continued from page 6 §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and staff interviews, the facility failed to implement their abuse policy in the areas of reporting and investigating an allegation of misappropriation. Upon the discovery of misappropriation, the facility did not submit a report to the State Agency or conduct a thorough investigation of the misappropriation. This failure occurred for 1 of 1 resident reviewed for misappropriation (Resident #24). The findings included: The facility's policy titled, "Abuse, Neglect and Exploitation", revised 06/01/25 read in part, "It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent ……. and misappropriation of resident property. “Misappropriation of Resident Property” means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident’s belongings or money without the resident’s consent. The facility will implement policies and procedures to prevent and prohibit all types of abuse to include misappropriation of resident property. V. Investigation: An immediate	F0607	Continued from page 6 facility acknowledged that reporting procedures under the Abuse Prevention Policy were not fully initiated at the time the medication irregularity was identified. On 2/11/2026 the Administrator and Director of Nursing immediately reviewed the facility’s Abuse Prevention and Reporting Policy with licensed nursing staff, emphasizing mandatory reporting timelines, immediate notification requirements, and documentation expectations in accordance with federal and state regulations. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Director of Nursing conducted a 30-day look-back review of incident reports, medication variances, and grievance logs to identify any additional medication irregularities that may have required abuse or misappropriation investigation and reporting. Additionally, interviews were conducted with licensed nurses to determine understanding of abuse reporting requirements related to suspected misappropriation or medication discrepancies. No additional unreported concerns were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility has implemented the following systemic changes: Re-education of all staff (licensed nurses, medication aides, and department heads) on the Abuse Prevention Policy, including definitions of abuse, neglect, exploitation, and misappropriation, and required reporting timeframes (immediate reporting to the Administrator/DON and to the State Agency as required). Implementation of a standardized Abuse/Allegation Reporting Checklist to ensure all potential allegations, including medication discrepancies, are evaluated promptly under F607 requirements. Revision of the Medication Variance Policy to include automatic review by the Administrator or DON to determine if abuse reporting criteria are triggered. Incorporation of abuse reporting competency into new	

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F0607 SS = D	Continued from page 7 investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. VII. Reporting: The facility will have written procedures that include reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services and to all other required agencies e.g., law enforcement when applicable within specified timeframes……. Resident #24 was admitted to the facility on 07/24/23 with diagnoses that included diabetes mellitus. Review of the quarterly Minimum Data Set assessment dated 01/18/26 revealed Resident #24 was cognitively intact. Review of Resident #24's physician orders revealed an order dated 09/11/25 for tirzepatide (Monjaro) 5 milligrams (mg) per 0.5 milliliters (ml) administer one syringe subcutaneously once a day on Friday for Type 2 Diabetes Mellitus. On 02/08/26 at 12:17 PM and interview was conducted with Resident #24. The Resident reported that about a month ago (12/12/25) a nurse (Nurse #1) went to administer her weekly "Mounjaro" (tirzepatide) injection that she took for her diabetes, which helped her lose weight, but the syringe was empty. She explained that the Nurse returned with another syringe from the refrigerator and that syringe was empty as well. Resident #24 stated that she did receive her weekly injection of "Mounjaro", but it was two or three days late because they had to get it from the pharmacy. She reported that she has never had the nurses attempt to give her the injection and the syringe be empty before that day (12/12/25). An interview was conducted with Nurse #1 on 02/10/26 at 9:31 AM. The Nurse reported that she worked on first shift on 12/12/25 and went to administer the tirzepatide to Resident #24 using the pen she got from the refrigerator. She stated she tried to unlock the pen, but it was already unlocked and the purple cap was depressed signifying the pen was empty. The Nurse stated she notified the Unit Manager that the pen was empty, and they went to the medication room refrigerator to discover that the last remaining tirzepatide pen belonging to Resident #24 was empty as well. Nurse #1 stated she explained to Resident #24 that the pens were empty, and they would get more medication from the pharmacy, and she would get the injection the next day. On 02/09/26 at 3:08 PM an interview was conducted with	F0607	Continued from page 7 employee orientation and annual mandatory in-service training. Leadership review of all medication discrepancies daily during morning clinical meeting to determine reportability. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The Administrator or designee will audit all incident reports, medication variances, and grievance reports weekly for four (4) weeks to ensure appropriate abuse policy review and reporting determinations are completed. Thereafter, audits will be conducted monthly for two (2) additional months. The Administrator will be responsible for reporting findings to the Quality Assurance and Performance Improvement (QAPI) Committee to evaluate compliance and identify trends. If non-compliance is identified, additional education and corrective action will be implemented. Date of Compliance: 2/20/26	

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F0607 SS = D	Continued from page 8 the Unit Manager (UM) who was the acting Director of Nursing on 12/12/25. The UM explained that Resident #24 received weekly injections of tirzepatide on Fridays and on the morning of 12/12/25, Nurse #1 informed her that she went to administer the tirzepatide injection to Resident #24 but could not get the lock mechanism on the syringe to unlock to inject the medication. It was discovered that the syringe had already been used. The Unit Manager stated they went to the medication room refrigerator to investigate the remaining tirzepatide syringe and discovered that the remaining syringe had been activated as well and both syringes were empty. She stated she determined that the two syringes were empty by comparing them to another resident's tirzepatide prefilled syringe and the other resident's syringe did not have the purple cap depressed. The UM explained that after the medication had been injected the purple cap remained depressed which indicated the syringe was empty. The UM continued to explain that she reported the issue to the Administrator, the Regional Clinical Manager and informed the Nurse Practitioner (NP) of the issue, who gave her a verbal order to hold the medication for 12/12/25 until it was obtained from the pharmacy on 12/13/25. The UM reported that she called the pharmacy and discussed the issue with someone (she could not remember who) and reported that there were two syringes left and both syringes looked as if they were empty, but she could not determine why the syringes were empty and Resident #24 needed her injections. She stated the pharmacy told her that they could send the medication with a new order which she obtained from the Nurse Practitioner and the tirzepatide injection was given to Resident #24 on 12/13/25. The Unit Manager stated she did not think about misappropriation of medication or to investigate about what happened or why the tirzepatide syringes were empty because she was new to the position and the only thing on her mind was what she could do to prevent it from happening again. During an interview with the Administrator on 02/11/26 at 3:19 PM the Administrator explained that she was notified on 12/12/25 by the Unit Manager via telephone about the empty tirzepatide pens but the Unit Manager did not go into detail, nor did the Administrator think to ask for the details. She stated she thought the Unit Manager was going to investigate the issue. The Administrator stated she should have been more diligent in the investigation to determine how the pens were emptied but she did not. The Administrator stated she did not think about misappropriation of medications because if she had thought about it, she knew she had to report misappropriation and she would have reported it.	F0607		

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F0607 F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F0607 F0880	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #10 was immediately assessed by the Interim Director of Nursing (DON) and the Unit Manager following the identified observation on 02/10/2026. The wound sites were evaluated for any signs and symptoms of infection (redness, warmth, drainage, odor, increased pain, or change in wound status). No adverse outcomes were identified at the time of review. On 2/10/26 the Interim DON provided education to the Wound Nurse on the facility's Hand Hygiene Policy and Basics of Hand Hygiene policy, specifically emphasizing hand hygiene before donning clean gloves and after removal of soiled gloves during wound care. A return demonstration of proper wound care technique, including appropriate hand hygiene between glove changes, was completed and validated by the DON on 2/11/26. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 2/10/26 a 100% audit of all residents currently receiving wound care was conducted by the DON and/or designee to ensure proper infection control practices were being followed and to assess for any signs or symptoms of infection for resident's receiving wound care. There were no negative findings. On 2/10/26 the interim DON/designee reviewed infection surveillance logs for the past 30 days to identify any trends or patterns related to wound infections. No patterns related to hand hygiene noncompliance were identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All licensed nurses (RNs/LPNs), including the Wound Nurse and Medication Aides, received mandatory re-education on: The facility's Hand Hygiene Policy CDC guidelines for hand hygiene Infection control standards related to glove use and wound care procedures	02/20/2026

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F0880 SS = D	Continued from page 10 (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 reviews and staff interviews, the facility failed to follow their Hand Hygiene Policy when the Wound Nurse performed pressure ulcer treatments on Resident #10 and did not wash or sanitize her hands before applying clean gloves. This deficient practice occurred for 1 of 7 staff members observed for infection control practices (Wound Nurse). The findings included: Review of the facility's Hand Hygiene policy read in part: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Review of the facility's Basics of Hand Hygiene policy read in part: You should always perform hand hygiene: before applying and after removing personal protective equipment (e.g., gloves), before and after providing any type of care and after contact with bodily fluids or other	F0880	Continued from page 10 The requirement to perform hand hygiene after removal of gloves and before donning clean gloves, regardless of visible soilage Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The Iinterim DON/designee or designee will conduct: weekly wound care observation audits for 4 weeks, bi-weekly audits for the following 2 months, then monthly audits thereafter for an additional 3 months. The Administrator will take audit results to the monthly QAPI Committee meeting. Any identified noncompliance will result in immediate re-education and progressive disciplinary action if indicated. Date of compliance is 2/20/2026	

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F0880 SS = D	Continued from page 11 potentially contaminated surfaces. Wound care observations were made on 02/10/26 at 2:15 PM on Resident #10 by the Wound Nurse. The Wound Nurse gathered the supplies and placed them on an over bed table that had been disinfected and a protective barrier had been placed on the table. The Wound Nurse washed her hands and applied a gown and gloves for the procedure. The Resident had been positioned on her right hip exposing her left hip wound where the Wound Nurse removed the dirty dressing, removed her gloves and applied clean gloves without performing hand hygiene. The Wound Nurse then cleansed the wound with a cleansing solution and applied skin prep. The Wound Nurse removed her gloves, sanitized her hands and applied clean gloves before she applied a foam dressing to the wound. The Wound Nurse then removed her gloves but did not perform hand hygiene before she applied clean gloves. Resident #10 was then positioned on her left side to expose wounds on her sacrum and right hip. The Wound Nurse then removed the dirty dressing from Resident #10's sacrum, removed her dirty gloves and performed hand hygiene before she applied clean gloves. She then cleansed the wound with a wound cleanser and removed her dirty gloves and without performing hand hygiene the Wound Nurse applied clean gloves and applied a soaked gauze and covered the gauze with a foam dressing then removed her gloves and performed hand hygiene before she applied clean gloves. The Wound Nurse then removed the dirty dressing from Resident #10 right hip and removed her dirty gloves then she washed her hands before she applied clean gloves. She then cleansed the wound with a wound cleanser and removed her dirty gloves and applied clean gloves without performing hand hygiene. The Wound Nurse then applied a soaked gauze to the wound and covered it with a foam dressing and removed her gloves and performed hand hygiene. Interviews were conducted with the Wound Nurse on 02/10/26 at 2:50 PM and 02/11/26 at 10:40 AM. The Wound Nurse stated that she did not realize that she did not wash or sanitize her hands each time after she removed dirty gloves and before she applied clean gloves and stated that she knew that she was supposed to. She stated that she had to change gloves numerous times during Resident #10's treatment that she must have lost track, and she was nervous being watched. During an interview with the Infection Preventionist (IP) on 02/13/26 at 10:35 AM the IP indicated that according to the facility's policy and standard practice of handwashing the Wound Nurse should have washed or sanitized her hands every time she removed	F0880		

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F0880 SS = D	Continued from page 12 her gloves whether they were visibly soiled or not. An interview was conducted with the Administrator on 02/11/26 at 3:30 PM. The Administrator explained that she had been made aware of the Wound Nurse not washing or sanitizing her hands between glove changes and the Wound Nurse told her she was nervous. The Administrator stated she had not heard of any problems with the Wound Nurse's wound treatment technique of not washing her hands after removing dirty gloves and before applying clean gloves previously. The Administrator indicated her expectation was that the Wound Nurse perform the treatments according to the professional standards of wound care and handwashing.	F0880		