STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345240	A. BUILDING B. WING	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Hills Nursing Center	864 US HWY 158 Business West , Warrenton, North Carolina, 27589

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/23/26 through 02/26/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1E498E-H1.	E0000		03/28/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/23/26 through 02/26/26. Event ID# 1E498E-H1. The following intakes were investigated #840963, #2622810, and #2698233. 4 of the 4 complaint allegations did not result in deficiency.	F0000		03/28/2026
F0584 SS = A	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services	F0584		03/28/2026

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: 345240	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026

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F0584 SS = A	Continued from page 1 necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to maintain a clean and sanitary homelike environment as evidenced by dried substance on the resident wall next to the bed and dried substances observed on the middle and lower portion of the privacy curtain for 1 of 3 resident rooms on 1 of 4 halls observed for clean and homelike environment (Resident #75 and Resident #37). The findings included: An observation of Residents #37 and Resident #75's room was conducted on 2/23/26 at 1:08 pm and revealed the following: the wall next to Resident #75, who had his bed positioned with the side of the bed touching the wall, was noted with multiple dried substances of varied colors and thickness in a line (wiped or smeared) pattern and the privacy curtain, which was hung between both resident beds, was noted with 10 dark brown colored spots, circular and linear in shape, on the lower portion of the privacy curtain and 5 areas of dried tan/cream-colored stains, circular and linear in shape, on the middle portion of the privacy curtain. Further observations of Residents #37 and Resident #75's room on 2/24/26 at 9:03 am, 2/25/26 at 10:45 am	F0584		

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F0584 SS = A	Continued from page 2 and 2/26/26 at 9:05 am revealed no changes of the environment from the initial observation on 2/23/26. An attempt to interview the Housekeeper #2 assigned to Resident #37 and Resident #75's room on 2/23/26 and 2/24/26 was unsuccessful. An interview was conducted with Housekeeper #1 on 2/26/26 at 9:05 am who revealed she was assigned to the residents' room today but had not yet been in the room to clean. Housekeeper #1 observed the room and confirmed the wall should have been sprayed and wiped clean and the privacy curtain should have been taken down and laundered due to the dried substance and stains when the room was cleaned earlier in the week. Housekeeper #1 stated she was not assigned to clean Resident #37 and Resident #75's room from 2/23/26 through 2/25/26 and she was unable to state how long the wall and privacy curtain was soiled. The Housekeeping Supervisor was interviewed on 2/26/26 at 9:12 am who confirmed the wall and privacy curtain in the resident's room should have been identified and cleaned during the normal cleaning process. He stated based on his observation the wall and privacy curtain should have been identified by the housekeeping staff at some time over the last few days and cleaned properly. The Housekeeping Supervisor stated he did spot check rooms at times to ensure cleaning was being completed as expected but he was not able to state if he had checked this particular room prior to the observations on 2/23/26 and 2/24/26. During an interview and observation with the Administrator on 2/26/26 at 9:28 am, the Administrator confirmed the wall and the privacy curtain in the resident's room should have been cleaned by the housekeeping staff.	F0584		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must	F0641	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.	03/28/2026

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F0641 SS = D	Continued from page 3 conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) Assessments for 3 of 29 residents whose MDS assessments were reviewed for accuracy (Resident #2, Resident #28 and Resident #38). The findings included: 1. Resident #2 was admitted to the facility on 9/08/21 with diagnoses which included dementia with behaviors. The wound provider visit note dated 1/16/26 revealed Resident #2 was treated for a stage 4 pressure ulcer to the sacrum, a stage 3 pressure ulcer to the left buttock, and an unstageable deep tissue injury (DTI) to the right heel. The Minimum Data Set (MDS) quarterly assessment dated	F0641	Continued from page 3 Resident #2 Minimum data set (MDS) Quarterly assessment with Assessment Reference date of 1/25/2026 reviewed and section M0300 section D1 incorrectly coded for indication noted for stage 4 pressure ulcers. Assessment correction completed on 2/27/2026 for item M0300-D1 by the MDS LPN. Resident #28 Minimum data set Admission assessment with Assessment Reference date of 2/12/2026 reviewed and section O0110 section O1 incorrectly coded for indication noted for IV Access Assessment correction completed on 2/27/2026 for item O0110-O1 by the MDS LPN. Resident #38 Minimum data set Admission assessment with Assessment Reference date of 12/15/2025 reviewed and section N0415 item I incorrectly coded for indication noted for Anti-platelet medication Assessment correction completed on 2/27/2026 N0415 item I by the MDS LPN. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of the current residents' most recent Minimum data set assessments that have been accepted in IQIES that have been completed for residents with High-Risk Drug Classes, Special Treatments, Procedures, and Programs, and Skin Conditions in order to identify assessments coded correctly at N0415 item I, O0110 section O1, and M0300-D1. Results are 37 of 37 resident assessments were in compliance. This audit was completed by regional Resident Assessment Instrument consultant on 3/6/2026--. No assessments identified as having inaccurate coding of N0415 item I, O0110 section O1, M0300-D1 requiring a correction of assessments completed. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. By 3/18/2026 the regional Minimum data set consultant will complete an in-service training with the facility Minimum Data Set Nurse that includes the importance that the assessment is coded accurately. Special emphasis will be placed on the following area of the Minimum Data Set assessment:	

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F0641 SS = D	Continued from page 4 1/25/26 revealed Resident #2 was coded for one stage 3 pressure ulcer and one unstageable deep tissue injury (DTI). An interview was conducted with the MDS Nurse on 2/25/26 at 3:38 pm who confirmed Resident #2 had a stage 3 pressure ulcer, a stage 4 pressure ulcer, and a DTI at the time of the MDS quarterly assessment based on the documentation from the wound provider. The MDS Nurse stated she just overlooked the stage 4 pressure ulcer when she completed Resident #2's quarterly assessment. During an interview conducted on 2/26/26 at 12:18 p.m., the Administrator stated that the MDS Nurse was responsible for accurately completing Resident #2's MDS assessment for pressure ulcers. The Administrator stated the MDS Nurse had the information for Resident #2's pressure ulcers and the assessment should have been accurately coded. 2. Resident #28 was admitted to the facility on 2/06/26 with diagnoses which included osteomyelitis (infection of the bone) of the right ankle and foot. Resident #28 had a physician order dated 2/07/26 for vancomycin intravenous (IV) solution; use 1.25 gram intravenously every 24 hours for infection related to osteomyelitis right ankle and foot until 3/04/26. The care plan dated 2/09/26 revealed Resident #28 had a care plan in place for IV medication via PICC (peripherally inserted central catheter used for long-term intravenous access) with risk for complications such as infection and infiltration. The Minimum Data Set (MDS) admission assessment dated 2/12/26 revealed Resident #28 was cognitively intact. The MDS assessment further noted that Resident #28 was coded for intravenous medication use but was not coded for IV access. During an interview conducted on 2/25/26 at 3:38 p.m., the MDS Nurse stated that Resident #28's PICC IV access should have been coded as IV access on the assessment. She acknowledged that she inadvertently overlooked the IV access when completing Resident #28's assessment.	F0641	Continued from page 4 N0415 High-Risk Drug Classes: Indication O0110 Special Treatments, Procedures, and Programs M0300 Skin Conditions The MDS needs to be thoroughly reviewed for accuracy prior to saving and signing section N0415, O0110, M0300 of the assessment. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. Education and training to be completed by DON or designee. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Administrator or designee will begin auditing 5 random recently completed minimum data set assessments for accuracy in coding on the Minimum data set assessment for item N0415 High-Risk Drug Classes, M0300 Skin Conditions and O0110 Special Treatments, Procedures, and Programs. This audit will be done weekly x 4 weeks, then monthly x 2 months using the audit tool titled "Accurate Coding of MDS Audit Tool". Indication to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. Reports will be presented to the Quality Assurance committee weekly by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed weekly with the Quality Assurance Committee. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. The Administrator and/or Director of Nursing are responsible for implementing the acceptable plan of correction; Date of compliance 3/28/2026	

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F0641 SS = D	Continued from page 5 During an interview conducted on 2/26/26 at 12:18 p.m., the Administrator stated that the MDS Nurse was responsible for accurately completing Resident #28's MDS assessment. She further explained that Resident #28's assessment should have been coded accurately for the IV access. 3. Resident #38 was admitted to the facility on 3/11/2019 with diagnoses that included coronary artery disease and cerebral infarction. Review of Resident #38's electronic health record revealed a physician's order dated 3/11/19 for Clopidogrel (an antiplatelet medication) 75 milligram (mg) one tablet by mouth daily. A review of Resident #38's December 2025 Medication Administration Record (MAR) revealed documentation of Clopidogrel 75mg one tablet by mouth daily. A review of Resident #38's quarterly Minimum Data Set (MDS) assessment dated 12/15/25 revealed Resident #38 was coded as receiving an anticoagulant. An interview was conducted with Support Nurse #2 on 2/26/26 at 1:11 PM. Support Nurse #2 confirmed she had completed Resident #38's quarterly MDS dated 12/15/25. Support Nurse #2 indicated she was being trained to complete the MDS. She stated that coding Resident #38 as receiving an anticoagulant was an error. During an interview with the Administrator on 2/2626 at 2:30 PM she stated Resident #38's MDS assessment should have been coded accurately.	F0641		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion	F0688	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 2/25/2026, the Licensed Practical Nurse (LPN) Charge nurse applied the prescribed resting hand splint to resident #6 hand per order, care plan, and therapy	03/28/2026

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F0688 SS = D	Continued from page 6 receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and staff interviews, the facility failed to place a resting hand orthosis (RHO, a device designed to support the hand, wrist, and fingers in a functional position) to the right hand for contracture management for 1 of 3 resident reviewed for position, mobility and range of motion (Resident #6). The findings included: Resident #6 was admitted to the facility on 11/18/25 with diagnoses which included stroke with hemiparesis (weakness caused by stroke) affecting the right dominant side. The care plan initiated on 11/19/25 and under review on 2/23/26 revealed Resident #6 had right hemiplegia/hemiparesis related to stroke with interventions which included perform range and motion exercises with am and pm care daily, apply RHO daily, complete hand hygiene and skin checks. The Minimum Data Set (MDS) admission assessment dated 11/24/25 revealed Resident #6 had severe cognitive impairment and was coded for functional limitation in range of motion on the upper and lower extremity on one side. The Occupational Therapy (OT) Discharge Summary dated 2/06/26 revealed Resident #6 was discharged from OT services due to reaching her maximum potential and an order for the RHO was in place. The OT discharge summary further noted that Resident #6's family and the nursing staff were provided education on splinting. Resident #6 had a physician order dated 2/06/26 for	F0688	Continued from page 6 recommendations. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 3/6/2026, the Director of Nursing (DON) and designee completed 100% audit of all residents with orders for splints that splints were applied per order. Results included: 11 of 11 residents had splints in place as ordered. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 3/3/26, the Director of Nursing began education of all Full Time, Part Time, Per Diem licensed nurse and certified nursing assistants to include agency staff on Splints and other devices to include: Documentation Care plan development Staff roles Applying devices per physician orders The Director of Nursing will ensure that any staff identified above will not be allowed to work as of 3/27/2026 until education is completed. This information has been integrated into the standard orientation training by DON or designee and in the required in-service refresher courses for all staff, to include agency staff, identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses who give residents care in the facility. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON or designee will monitor compliance utilizing F688 Quality Assurance (QA) Tool weekly x 3 weeks then monthly x 2 months. Monitoring tools completed by the DON or designee will monitor 4 residents with splints to ensure they are applied, applied correctly, and skin	

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F0688 SS = D	Continued from page 7 splint; apply right upper extremity RHO daily, complete hand hygiene and skin checks every day shift to prevent contracture and skin breakdown. Observations were conducted on 2/23/26 at 10:56 am, 12:57 pm, and 2:45 pm of Resident #6. Resident #6 was observed in bed without a splint in place. Resident #6's right arm rested along the abdomen and leg with slight bend noted at the wrist that did not appear to be lying flat. The splint was observed to be on the table in the room. Observations of Resident #6 were conducted on 2/24/26 at 8:28 am, 12:06 pm, and 2:44 pm. Resident #6 was observed in bed without the splint in place. The splint was observed to be on the table in the room. The Treatment Administration Record (TAR) revealed Resident #6 was documented to have the right upper extremity splint in place on 2/23/26 and 2/24/26 by Nurse #3. An interview was conducted with Nurse #3 who revealed the therapy staff placed Resident #6's right upper extremity splint and would then notify her that it was in place and she documented the splint as in place on the TAR. Nurse #3 stated she believed the splint was to stay in place for 8 hours but she did not manage the splint placement or removal for Resident #6. The Rehabilitation Manager was interviewed on 2/25/26 at 3:15 pm who revealed the therapy staff were responsible for Resident #6's right upper extremity RHO splint when she was on the therapy caseload but once the resident was discharged from therapy services the nursing department was responsible for the splint. The Rehabilitation Manager stated once Resident #6 discharged from therapy on 2/06/26 a physician order was placed for nursing to manage the splinting for the right upper extremity. She stated the therapy department met with nursing staff and provided education regarding the use and management of the right upper extremity RHO and signed off the care to nursing. The Rehabilitation Manager stated Resident #6's splint was recommended to be worn for up to 4 hours during the day shift. During an interview on 2/25/26 at 4:26 pm the Director of Nursing (DON) stated once the resident was no longer on therapy the Nurse was responsible for putting the	F0688	Continued from page 7 integrity. Monitoring will begin on 3/30/2026. Reports will be presented to the Quality Assurance committee weekly by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed weekly with the Quality Assurance Committee. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. The Administrator and/or Director of Nursing are responsible for implementing the acceptable plan of correction; Date of Compliance: 3/28/2026	

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F0688 SS = D	Continued from page 8 splint in place for Resident #6. The DON stated that Nurse #3 would have seen the order for Resident #6's splint to place the splint on during the day shift so the order should have been followed by Nurse #3. The Administrator was interviewed on 2/26/26 at 12:22 pm and revealed that Nurse #3 would have been the staff member responsible to manage Resident #6's splint on 2/23/26 and 2/24/26 and Nurse #3 should have ensured the splint was in place as ordered.	F0688		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by:	F0690	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 2/25/2026, the assigned Licensed Practical Nurse (LPN) secured resident #22 indwelling catheter tubing using approved securement device to prevent tugging and pulling. On 2/25/2026, the assigned LPN assessed resident #22 for signs and symptoms of discomfort and trauma. Assessment revealed no pain or injury. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 2/25/2026, the Director of Nursing (DON) and designee completed 100% audit of all residents with indwelling catheters to ensure catheter tubing was properly secured and positioned to prevent pulling, tugging or tension. Any catheter tubing found unsecured was immediately corrected by the assigned nurse. Results included: 10 of 10 residents had securement device in place. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 3/3/2026, the Director of Nursing began education of all Full Time, Part Time, Per Diem licensed nurse and	03/28/2026

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Warren Hills Nursing Center	864 US HWY 158 Business West , Warrenton, North Carolina, 27589

(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
F0690 SS = D	Continued from page 9 Based on observation, record review and resident and staff interviews, the facility failed to secure the indwelling urinary catheter tubing to prevent tugging or pulling for 1 of 1 resident reviewed for indwelling urinary catheter (Resident #22). Resident #22 was admitted to the facility on 8/18/16 with diagnoses that included neuromuscular dysfunction of bladder and urinary retention. A physician's order dated 9/5/2025 indicated Resident #11 had an indwelling urinary catheter for urinary retention. The quarterly Minimum Data Set (MDS) Assessment dated 12/23/25 revealed Resident #22 was cognitively intact. He was coded as having an indwelling urinary catheter. An observation was conducted of wound care on 02/24/2026 at 2:17 PM with the Wound Nurse. During the observation Resident #22 did not have a leg band in place to secure the tubing for his indwelling urinary catheter. There was no tension on the catheter tubing during the observation. An interview was conducted with Resident #22 on 2/24/26 at 2:22 PM. Resident #22 stated that staff sometimes forgot to place a securement device on his indwelling urinary catheter tubing. Resident #22 was unable to say how long it had been since he's had a leg band on. Resident #22 denied any discomfort or tension on the catheter tubing. An observation was conducted of Resident #22's urinary catheter on 02/25/2026 at 9:54 AM with the Infection Preventionist. During the observation Resident #22 was observed to be lying in bed with urinary catheter tubing not secured. There was no tension on the catheter tubing during the observation. An interview was conducted with the Infection Preventionist (IP) on 2/25/2026 at 10:00 AM. The IP stated the resident was supposed to have a leg band in place because it prevented the indwelling catheter from becoming dislodged and causing trauma to the bladder. She stated the nurse on the hall was responsible for making sure the leg band was in place. The IP nurse further stated the nurse aide caring for the resident should let the nurse know when the leg band was not in place.	F0690	Continued from page 9 certified nursing assistants to include agency staff on Urinary Catheter care and procedure, emphasizing proper securement of indwelling catheters, why it is important and ongoing care and monitoring. The Director of Nursing will ensure that any staff identified above will not be allowed to work as of 3/27/2026 until education is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff, to include agency staff, identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The DON or designee will complete orientation education and training.The facility specific in-service will be provided to all agency Nurses who give residents care in the facility. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON or designee will monitor compliance utilizing F690 Quality Assurance (QA) Tool weekly x 3 weeks then monthly x 2 months. Monitoring tools completed by the DON or designee will monitor 4 residents with indwelling catheter securement and care. Monitoring will start on 3/30/2026. Reports will be presented weekly to the Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. The Administrator and/or Director of Nursing are responsible for implementing the acceptable plan of correction. Date of Compliance: 3/28/2026	

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F0690 SS = D	Continued from page 10 An interview was conducted with Nurse # 4 on 2/25/26 at 10:07 AM. Nurse #4 stated the nurse was responsible for checking to see if the resident had a leg band in place. Nurse # 4 stated he had not been made aware that Resident #22 did not have a leg band in place. During an interview with Nurse Aide (NA) #1 on 02/25/2026 at 2:14 PM, she stated the IP nurse had made her aware that Resident #22 did not have a leg band in place. NA #1 stated the resident usually had a leg band and she just had not gotten to him during her care rounds so that she could notify the nurse that the leg band was missing. NA #1 stated Resident #22 received his bath on the night shift. Multiple attempts to contact NA #2 who cared for Resident #22 the night of 2/24/26 (7:00 PM on 2/24/26 through 7:00 AM on 2/25/26) were unsuccessful. An interview was conducted with the Director of Nursing (DON) on 2/25/26 at 2:33 PM. The DON stated that the nurse or nurse aide should have made sure Resident #22's indwelling urinary catheter tubing had a securement device in place.	F0690		
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 observation, record review and staff and resident interviews, the facility failed to obtain a physician order for supplemental oxygen for 1 of 2 residents reviewed for respiratory care (Resident #28). The findings included: Resident # 28 was admitted to the facility on 2/06/26 with diagnoses which included cellulitis of the right lower leg and pneumonia.	F0695	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 2/24/2026, Minimum Data Set (MDS) Nurse transcribed order in electronic medical record for oxygen at 2 Liters per minute via Nasal cannula for resident #28. On 3/5/2026, Licensed Practical Nurse # 3 was re-educated on how to place order in electronic medical record by the Director of Nursing (DON). 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 2/26/2026, the Director of nursing and designee completed an audit of all current residents receiving	03/28/2026

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F0695 SS = D	Continued from page 11 The Minimum Data Set (MDS) admission assessment dated 2/12/26 revealed Resident #28 was cognitively intact and was not coded for supplemental oxygen therapy. The nursing progress note dated 2/14/26 at 11:27 am by Nurse #3 revealed Resident #28 complained of shortness of breath. Resident #28 was noted to have an oxygen saturation in the 80's (normal range of oxygen saturation is 95-100%) on room air. Nurse #3 placed 2 liters of supplemental oxygen via nasal cannula on Resident #28 and the oxygen saturation increased to 94 to 96%. Nurse #3 further noted that the provider was notified via electronic communication. An interview was conducted with Nurse #3 on 2/24/26 at 2:50 pm who revealed she did notify the provider on 02/14/26 that Resident #28 required oxygen and did get the order, but she stated she had trouble entering the order. Nurse #3 stated she could usually "fumble" her way through putting in an order, but she must have not realized the order for the oxygen was never put in when she had the trouble. She stated the Support Nurse normally entered physician orders, so it was not something she had to do often. Nurse #3 stated she did not notify any Support Nurse or reach out for assistance to enter Resident #28's oxygen order when she had difficulty entering the order on 02/14/26. A review of the physician orders revealed no physician order for supplemental oxygen use for Resident #28. An observation and interview were conducted with Resident #28 on 2/23/26 at 11:16 am. Resident #28 was observed with supplemental oxygen in place at 2 liters via nasal cannula. Resident #28 stated she had recently been diagnosed with pneumonia and had been on oxygen since having trouble breathing a while ago. Resident #28 stated the oxygen was not something she had required prior to coming to the facility. Support Nurse #2 was interviewed on 2/25/26 at 3:27 pm who confirmed she was the Support Nurse assigned to Resident #28. Support Nurse #2 stated that when additional orders were received by a provider the nurse that obtained the order was responsible to enter the order. Support Nurse #2 stated she just did not think to review Resident #28's order to make sure the oxygen	F0695	Continued from page 11 Oxygen Therapy to ensure there was a physician order in place for use of supplemental oxygen. The results included: 11 of 11 residents had continuous oxygen orders were in place for supplemental oxygen in use. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 3/ 3/26, the Director of Nurses/ Staff Development Nurse began education to all full time, part time, and Per Diem Nurses (including agency) on the following: All residents who require the use of supplemental oxygen must have an active physician order in place, to include the process of order entry. All residents who have ordered supplemental oxygen must a have oxygen signs in place outside of their room indicating that oxygen is in use. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff, to include agency staff, identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Orientation and training will be completed by DON or designee. The facility specific in-service will be provided to all agency Nurses who give residents care in the facility. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nurses or designee will monitor compliance utilizing the F695 Quality Assurance Tool to review 5 residents receiving supplemental oxygen weekly for 2 weeks then monthly x 3 months or until resolved. The DON will monitor that residents receiving oxygen have a physician order in place and have oxygen signage posted outside of their room. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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F0695 SS = D	Continued from page 12 order was in place. An attempt to conduct a telephone interview with the medical provider on 2/26/26 at 12:55 pm was unsuccessful. An interview was conducted with the Director of Nursing (DON) on 2/25/26 at 4:22 pm who revealed that Nurse #3 was responsible to notify the provider and enter any orders obtained for Resident #28's supplemental oxygen. The DON further noted that Nurse #3 should have reached out to her or asked another nurse that was working for assistance if she was having difficulty entering the oxygen order. The DON stated the physician orders were normally reviewed in the clinical meetings but she was unable to recall if Resident #28's orders were reviewed.	F0695	Continued from page 12 Date of Compliance: 3/28/2026	
F0757 SS = E	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 §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:	F0757	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. The facility failed to evaluate the continued need for a medication prescribed for wheezing. This deficient practice had the potential to result in residents receiving medications without clinical indication, ongoing monitoring, or justification of continued use for 1 of 6 residents reviewed unnecessary medications. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 2/25/2026, resident #75 had assessment completed of current respiratory status by Registered Nurse. This assessment was reported to assigned Physician's Assistant. On 2/28/2026, resident #75 had respiratory assessment completed by Respiratory Therapist and 3/3/2026 medication prescribed for wheezing reviewed by the Physician's Assistant and medication was discontinued. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	03/28/2026

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F0757 SS = E	Continued from page 13 Based on observation, record review, and interviews with staff, the Consultant Pharmacist, and the Physician Assistant, the facility failed to evaluate the continued need for a medication prescribed for wheezing. This deficient practice had the potential to result in residents receiving medications without clinical indication, ongoing monitoring, or justification of continued use for 1 of 6 residents reviewed unnecessary medications (Resident #75). The findings included: Resident #75 was admitted to the facility on 8/11/16 with diagnoses which included dementia without behavioral disturbances, pleural effusion (abnormal accumulation of excess fluid in the space between the lungs and chest wall), and congestive heart failure (CHF). The nursing progress note dated 11/20/25 at 8:03 pm revealed the Physician Assistant (PA) was notified by Nurse #2 that Resident #75 had a wheeze (a high-pitched, whistling sound produced during breathing caused by narrowed or obstructed airways). Nurse #2 noted that the PA ordered a chest x-ray and ipratropium bromide 0.5 milligram (mg)/albuterol sulfate 2.5 mg, 3 mg/3 milliliters, inhalation solution (combination bronchodilator medication used via a nebulizer to open airways and reduce mucus) every 4 hours. Resident #75 had an active physician order dated 11/20/25 for ipratropium bromide 0.5 milligram (mg)/albuterol sulfate 2.5 mg, 3 mg/3 milliliters, inhalation solution. Administer one (1) inhalation orally via nebulizer (medical device used to deliver medication directly to the respiratory system) every 4 hours for wheezing. The health status note dated 11/23/25 revealed Resident #75's radiology results for the chest x-ray revealed no acute findings. The PA was notified and no new orders were received. The Minimum Data Set (MDS) quarterly assessment dated 11/23/25 revealed Resident #75 had moderate cognitive impairment with unclear-slurred or mumbled words.	F0757	Continued from page 13 On 2/26/2026 the Director of Nursing (DON) and designees completed 100% audit was conducted of all residents currently prescribed per resident need (PRN) or routine nebulizer treatments to ensure: A documented clinical indication Evidence of ongoing assessment and monitoring Provider documentation supporting continued need Results included: no additional concerns noted. No additional identified medications were lacking appropriate justification to require review by the provider, and orders were clarified, modified, or discontinued as appropriate and documented in residents' medical record by the assigned nurse. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 3/3/2026, the DON and designee began education of all Full Time, Part Time, and as needed licensed nurses, medication administration aides & Providers on CMS requirements under F757, documentation of respiratory status, proper documentation of clinical indications and effectiveness, and reassessment for continued need for breathing treatments. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff, to include agency staff, identified above and will be reviewed by the Quality Assurance (QA) process to verify that the change has been sustained. The DON or designee will complete all orientation education and training. Any staff that has not received scheduled in-service training will not be allowed to work until training has been completed by 3/27/2026. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing or designee will monitor compliance of unnecessary medication process by monitoring 4 residents receiving breathing treatments (scheduled and As Needed) for appropriate clinical indication, evidence of ongoing monitoring of respiratory status, and provider documentation of continued need for breathing treatments. This	

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F0757 SS = E	Continued from page 14 The Medical Director visit note dated 12/02/25 revealed Resident #75 denied chest pain and shortness of breath. Resident #75 was noted to have even and unlabored respirations which were clear to auscultation (listening by stethoscope). The Medical Director visit note dated 1/20/26 revealed Resident #75 denied chest pain and shortness of breath. Resident #75 was noted to have even unlabored respirations which were clear to auscultation. The PA visit note dated 1/30/26 revealed Resident #75 had no complaints, denied any chest pain, shortness of breath, or other discomforts. The PA further noted the resident did not exhibit any signs of respiratory distress and was found to have clear lungs without wheeze. The Medical Director visit note dated 2/17/26 revealed Resident #75 denied any shortness of breath and was noted to have even and unlabored respirations which were clear to auscultation. The Medication Administration Record (MAR) for November 2025 through February 2026 revealed Resident #75 was administered the medication as ordered with the exception of refusals. The medication was last administered on 2/25/26 at 12:00 pm. An observation was conducted on 2/23/26 at 1:10 pm of Resident #75. Resident #75 was in bed with no wheeze or shortness of breath noted. A nebulizer machine was noted to be placed at the foot of the bed. Support Nurse #2 was interviewed on 2/25/26 at 3:21 pm who confirmed she was responsible for the oversight of Resident #75. Support Nurse #2 stated that she was not sure why Resident #75 was still receiving the bronchodilator medication because she had not observed any wheezing from the resident. She stated she had discussed Resident #75 with nursing staff on 2/25/26 and no staff member had reported continued wheezing to support the need for the medication. Support Nurse #2 stated she would discuss discontinuation of the medication with the PA. A telephone interview was conducted on 2/25/26 at 2:42	F0757	Continued from page 14 monitoring will be completed weekly x 2 weeks and then monthly times 3 months or until resolved. Reports will be presented to the Quality Assurance committee weekly by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed with the Quality Assurance Committee weekly. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Therapy Manager, Health Information Manager, Social Service Director, and the Dietary Manager. Date of Compliance: 3/28/2026	

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F0757 SS = E	Continued from page 15 pm with the Consultant Pharmacist who revealed she reviewed Resident #75's medications monthly during the medication regimen review to evaluate the need of the medications prescribed. The Consultant Pharmacist stated she would not address the bronchodilator medication order with the provider because based on the PA visit notes the provider reviewed medications and noted to continue with current treatment plan for Resident #75. A telephone interview was conducted with the Physician Assistant on 2/26/26 at 11:21 am. The PA reported that Resident #75 had CHF with occasional wheeze so the medication order would be warranted to be an as needed (PRN) order. The PA stated she had not observed Resident #75 to have wheezing and it had not been reported by any staff so she would not have expected the medication to continued being used. The PA stated she did review the medications and assess Resident #75 at each visit, but she was not aware the medication continued to be administered, and she did not notice the order was not written for an as needed medication. An attempt to conduct a telephone interview with the Medical Director on 2/26/26 at 12:55 pm was unsuccessful. During an interview with the Director of Nursing (DON) on 2/26/26 at 10:32 am she revealed that when the order was initially received for Resident #75 it should have been written as a PRN order instead of scheduled. The DON stated that the nursing staff should have identified no symptoms were being exhibited by Resident #75 and contacted the provider to discuss changing the order to PRN or discontinuing the order. The DON stated that while physician orders were reviewed in the clinical meeting, they normally reviewed new orders during the meeting and did not have a process in place for older standing orders. The Administrator was interviewed on 2/26/26 at 12:24 pm and she stated the PA wrote the order for Resident #75's medication and should have identified it was ordered and remained in place as routine for the extended period.	F0757		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F0761	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of	03/28/2026

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F0761 SS = D	Continued from page 16 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and staff interviews the facility failed to date open medications for 1 of 3 medication carts reviewed for medication storage (Hall 100 medication cart). The findings included: During an observation of Hall 100 medication cart with Nurse #1 on 2/24/26 at 3:15 pm the following was observed: - one plastic squeeze bottle of brimonidine/timolol solution 0.2/0.5% eye drops (a medication used to treat eye conditions like glaucoma) was observed open with no open date noted. The manufacturer's recommendation for the brimonidine/timolol solution 0.2/0.5% was to be used or discarded within 4 weeks of opening. - one plastic squeeze bottle of olopatadine solution 0.2% eye drops (an antihistamine eye drop used for relief of allergic conjunctivitis) open with no open	F0761	Continued from page 16 compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. The facility failed to date open medications for 1 of 3 medication carts reviewed for medication storage (Hall 100 medication cart). 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 2/24/2026, Licensed Practical Nurse #1 disposed of undated bottle of brimonidine/timolol solution 0.2/0.5% eye drop and bottle of olopatadine solution 0.2% eye drops. On 3/3/2026, the Director of Nursing (DON) re-educated Nurse #1 on medication storage policy and dating of medication opened on medication carts. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 3/25/2026, the DON and unit managers conducted 100% cart audits for undated/expired medications. No other undated/expired medications found. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 3/3/2026, the DON began education of all Full Time, Part Time, Per Diem and Agency Nurses, Medication Aides on Medication Storage and dating medications opened on medication carts. The education was provided: Medication storage policy of dating medication when opened. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff, to include agency staff, identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The DON or designee will complete the orientation education and training. Any staff who does not receive scheduled in-service training by 3/27/2026 will not be allowed to work until training has been completed. 4. Indicate how the facility plans to monitor its	

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F0761 SS = D	Continued from page 17 date noted. The manufacturer's recommendation for the olopatadine solution 0.2% eye drops was to be used or discarded within 4 weeks of opening, even if the bottle was not empty. Nurse #1 was interviewed on 2/24/26 at 3:19 pm who revealed the medications were to be dated when initially opened. Nurse #1 stated she was not present when the medications were opened and was unable to state why they were not dated. An interview was conducted with the Director of Nursing (DON) on 2/25/26 at 3:03 pm who revealed the medications were to be dated when opened by the nurse. The DON further stated that nurses should check any medication that was open to ensure an open date was noted before use on the resident.	F0761	Continued from page 17 performance to make sure that solutions are sustained. The DON and/or designee will monitor medication carts to assure that medications that are opened are dated per policy. Monitoring of 2 medication carts will be completed 2 x per week for 2 weeks, weekly x 2 and then monthly x 3 or until resolved. Reports will be presented to the Quality Assurance committee weekly by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed with the Quality Assurance (QA) Committee weekly. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 3/28/2026	
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F0880	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 3/5/2026, the Director of Nursing (DON) re-educated Registered Nurse #3 and the Wound Licensed Practical Nurse (LPN) on the facility's infection Control Program and Hand Hygiene Policy. On 3/24/2026, the Director of Nursing observed a return demonstration of correct hand hygiene and glove use by Registered Nurse #3 during medication administration process to include IV medications. On 3/25/2026, the Director of Nursing observed the wound nurse LPN. No issues were identified during the direct observation. Resident #22 and resident #2 were assessed for any signs or symptoms of infection by the Wound specialist physician on 2/27/2026. No adverse outcomes were identified. Resident #28 was assessed by the LPN on 2/27/2026 and by the Nurse Practitioner on 3/5/2026 for any signs or symptoms of infection. No adverse outcomes were	03/28/2026

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F0880 SS = E	Continued from page 18 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and staff interviews the facility failed to implement their infection prevention program policies and procedures and follow their Hand Hygiene policy when Nurse #3 failed to perform hand hygiene and change gloves when	F0880	Continued from page 18 identified. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 3/24/2026, the Director of Nursing and administrative nurses began a 100% audit of all licensed staff for appropriate hand hygiene and proper glove usage by return demonstration. Results included: No additional concerns noted. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 3/3/26, the Director of Nursing began education of all Full Time, Part Time, Per Diem licensed nurses and certified nursing assistants to include agency, on Infection Control, emphasizing Hand Hygiene and the prevention of infections during wound care and during IV & Central line care. The Director of Nursing will ensure that any staff identified above will not be allowed to work as of 3/27/2026 until education is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff, to include agency staff, identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The DON or designee will be conducting the orientation education and training. The facility specific in-service will be provided to all agency Nurses who give residents care in the facility. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON or designee will monitor compliance utilizing the F880 Quality Assurance (QA) Tool weekly x 3 weeks then monthly x 2 months. Monitoring tools will be completed by the DON or designee. 4 licensed staff members will be observed for compliance with hand hygiene, proper glove use, and appropriate procedure for wound care and IV/central line technique. Monitoring will start on 3/30/2026. Reports will be presented to the Quality Assurance committee weekly by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored, and the ongoing auditing program reviewed with the Quality Assurance Meeting weekly. The QA Meeting is attended by	

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F0880 SS = E	Continued from page 19 flushing a peripherally inserted central catheter (PICC) line (a long thin flexible tube inserted through an arm vein near the heart for long term intravenous access) and connecting the intravenous (IV) antibiotic tubing to the PICC line tubing. In addition, the Wound Treatment Nurse failed to change the disposable gloves and perform hand hygiene during wound care observation for Resident #2 and Resident #22. The deficient practice occurred for 2 of 4 staff observed for infection control practices (Nurse #3 and Wound Nurse). The findings included: The facility's Infection Prevention and Control Standards policy, last approved September 2025, revealed the purpose of the policy was to implement the Infection Prevention and Control Program (IPCP) to minimize the risk of infection to the residents and staff. The policy further read that staff were to support resident safety by adhering to all policies and procedures related to infection prevention including standard and transmission-based precautions. The facility's Hand Hygiene policy, last approved June 2025, stated that hand hygiene was regarded as the single most important means of preventing the spread of infections. The policy further noted that hand hygiene was to be performed after contact with non-intact skin, before performing dressing care or touching wound of any kind, after handling used dressings, and after touching equipment or furniture that is near a resident. The IV Therapy policy last approved on October 2025 read in part that the PICC line flushing procedure stated the nurse was to wash hands thoroughly prior to flushing the PICC line. 1. A continuous observation of medication administration for Resident #28 was conducted with Nurse #3 on 2/24/26 at 9:13 am through 9:19 am. Nurse #3 was observed to don gloves, remove and prepare prescribed medications from the medication cart outside Resident #28's room. Nurse #3 was then observed to depress and lock the medication cart, gather the medications, which included IV antibiotics and enter Resident #28's room without removing her gloves or performing hand hygiene. Nurse #3 then administered the oral medications to Resident #28 and proceeded to prepare the IV antibiotics for administration through the PICC line in the right upper arm of Resident #28.	F0880	Continued from page 19 the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 3/28/2026	

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F0880 SS = E	Continued from page 20 Without removing her gloves and performing hand hygiene, Nurse #3 then hung the bag of IV antibiotics on the IV pole, inserted the end of the new IV tubing into the antibiotic bag, and primed the IV tubing (filled the tubing with the solution from the IV medication to remove air). Nurse #3 then opened the IV pump chamber and placed the IV tubing in the chamber and closed the chamber latch with the gloved hand. Nurse #3, without removing the gloves and performing hand hygiene, then removed the disinfecting cap from the PICC line, wiped the hub with an alcohol wipe, flushed the PICC line with normal saline, connected the IV tubing from the antibiotic to the PICC line and started Resident #28's IV antibiotics. Nurse #3 was observed to remove her gloves and perform hand hygiene with hand sanitizer and exited Resident #28's room at 9:19 am. An immediate interview was conducted with Nurse #3 on 2/24/26 at 9:20 am who revealed she should have removed the gloves after pulling the medications from the medication cart, performed hand hygiene, and put on clean gloves before working with Resident #28's IV antibiotic and PICC line. Nurse #3 was unable to state why she did not remove the gloves and perform hand hygiene before working with Resident #28's PICC line, she stated she "just didn't do it". The Infection Preventionist (IP) was interviewed on 2/26/26 at 8:57 am and revealed Nurse #3 should have removed the gloves and performed hand hygiene before she entered Resident #28's room to administer medications. The IP stated Nurse #3 was to perform hand hygiene and don clean gloves before she flushed the PICC line and administered the IV antibiotics to Resident #28. The Director of Nursing (DON) was interviewed on 2/25/26 at 4:22 pm. The DON stated that Nurse #3 should have removed the gloves worn and performed hand hygiene after preparing the medication, touching the medication cart, IV pole, and IV pump. The DON stated Nurse #3 was required to perform hand hygiene prior to flushing the PICC line and starting Resident #28's IV antibiotic. During an interview with the Administrator on 2/26/26 at 12:19 pm she revealed Nurse #3 should have performed hand hygiene prior to starting the process of administering Resident #28's IV antibiotic.	F0880		

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F0880 SS = E	Continued from page 21 2. A continuous observation of Resident #2's pressure ulcer treatment was conducted on 2/24/26 at 11:48 am through 12:00 pm with the Wound Treatment Nurse. The Wound Treatment Nurse was observed to perform hand hygiene, don clean gloves and prepared to cleanse Resident #2's sacral and left buttock pressure ulcers. The Wound Treatment Nurse was observed to spray the wound bed of the stage 4 sacral pressure ulcer with wound cleanser and wipe the wound bed with gauze. The stage 4 sacral pressure ulcer presented with slough (yellow/white, dead tissue that accumulates in the wound which harbors bacteria) present on the wound bed. The Wound Treatment Nurse then sprayed the stage 3 left buttock pressure ulcer with wound cleanser and wiped the wound bed with gauze. The Wound Treatment Nurse did not change gloves or perform hand hygiene after cleansing the stage 4 pressure ulcer and before cleansing the stage 3 pressure ulcer. The Wound Treatment Nurse was then observed to prepare and place the new wound treatment dressings on Resident #2's sacral and left buttock wounds. The Wound Treatment Nurse did not remove the soiled gloves or perform hand hygiene after cleansing Resident #2's pressure ulcers or before preparing and placing the wound treatments. The Wound Treatment Nurse was observed to remove soiled gloves and perform hand hygiene and exited Resident #2's room at 12:00 pm. An immediate interview was conducted with the Wound Treatment Nurse on 2/24/26 at 12:01 pm. The Wound Treatment Nurse stated she should have removed the soiled gloves and performed hand hygiene between cleaning the wounds and putting on new dressings. The Wound Treatment Nurse stated she was nervous and just forgot to change her gloves. An interview was conducted on 2/26/26 at 8:56 am with the Infection Preventionist (IP) who stated the Wound Treatment Nurse should have removed the soiled gloves and performed hand hygiene after cleansing Resident #2's pressure ulcers. The IP stated the new treatment dressings should not have been placed on the wound bed with the soiled gloves. During an interview with the Director of Nursing (DON) on 2/25/26 at 4:22 pm she revealed the Wound Treatment Nurse should have removed the gloves and performed hand hygiene after cleansing the wound beds and putting the new dressings on to prevent contamination of the new dressings.	F0880		

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F0880 SS = E	Continued from page 22 The Administrator was interviewed on 2/26/26 at 12:19 pm. The Administrator stated the Wound Treatment Nurse had been educated on the hand hygiene policy and should have followed the policy when the pressure ulcer treatment was completed. 3. An observation was conducted of wound care with the Wound Nurse for Resident #22 on 2/24/26 at 2:17 PM. The Wound Nurse was already in the resident's room when the surveyor entered the room. The Wound Nurse performed hand hygiene, donned a gown and clean gloves. The Wound Nurse removed the old dressing and without removing her gloves and performing hand hygiene the Wound Nurse proceeded to clean the pressure ulcer to Resident #22's left buttock with gauze soaked in wound cleanser. Without changing her gloves or performing hand hygiene the Wound Nurse opened the new dressings. The Wound Nurse then removed her gloves and completed hand hygiene. The Wound Nurse donned a new pair of gloves and placed calcium alginate (wound dressing) to the wound bed. The Wound Nurse then applied Zinc Oxide ointment to the wound edges and outer wound area. She then applied a dry dressing to left buttock wound, gathered trash, removed her gloves and completed hand hygiene. The Wound Nurse assisted Resident #22 on his back with the head of bed elevated. During an interview with the Wound Nurse on 2/24/26 at 2:33 PM, the Wound Nurse stated she should have removed her gloves and performed hand hygiene after removing the old dressing and prior to cleaning the wound. The Wound Nurse stated she became nervous and forgot this step. During an interview with the Infection Preventionist on 2/24/26 at 3:10 PM it was revealed that all staff received infection control training which included hand hygiene annually. The IP stated the Wound Nurse should have removed the old dressing, performed hand hygiene and donned a new pair of gloves prior to cleaning the wound. An interview was conducted with the Director of Nursing on 2/24/26 at 3:35 PM. The DON stated the Wound Nurse should have performed hand hygiene and changed her gloves to prevent cross contamination of Resident #22's wound. The DON stated the Wound Nurse should have performed hand hygiene and changed her gloves after	F0880		

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F0880 SS = E	Continued from page 23 removing the old dressing and prior to cleaning the wound.	F0880		