STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345463	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Hendersonville	**400 Thompson Street , Hendersonville, North Carolina, 28792**

(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 survey was conducted on 08/24/25 through 08/27/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ID44CA-H1 11.	E0000		09/09/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/24/25 through 08/27/25. Event ID#1D44CA-H1. The following intakes were investigated: 852248, 852249, and 852230. 7 of the 7 complaint allegations did not result in a deficiency.	F0000		09/17/2025
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility … must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a	F0727	The plan of correction is for the deficient practice. The plan should address the processes that lead to the deficiency. The facility failed to have scheduled a Registered Nurse (RN) for at least 8 consecutive hours a day for 5 out of the 6 days reviewed (2/1 and 2/2/25, 2/9/25, 3/1 and 3/2/25). The procedure for implementing the acceptable plan of correction for the specific deficiency cited: RN staffing coverage was reviewed for the rest of the schedule with the staffing coordinator to ensure there was at least 8 consecutive hours a day for 7 days a week. All employed unit managers and the staffing coordinator were in serviced by the Director of Nursing that there must be 8 consecutive hours a day for 7 days a week of Registered Nurse coverage and to ensure that they remain on the clock for the full 8 hours this education was completed by 9/12/25. The Director of Nursing cannot be included in the 8 hours of Registered Nurse coverage if the census is above 60. Residents residing in the facility have the potential to be affected by the deficient practice. The Director of Nursing and Assistant Director of Nursing or licensed nurse will review daily schedules to ensure that 8hrs of Registered Nursing coverage is occurring 7 days a week. Audits will be 5xweekly x 4 weeks, 3xtimes weekly x 4weeks, and then 1x weekly x 4 weeks. The monitoring process is to ensure that the plan of correction is effective and that the specific deficiency cited is in compliance with the regulatory requirements: Director of Nursing, staffing coordinator and/or assigned designee will monitor the daily schedule and time clock punches to ensure that there is 8 consecutive hours for 7 days a week of RN coverage.	09/18/2025

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

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

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F0727 SS = F	Continued from page 1 registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure Registered Nurse (RN) coverage was provided for at least 8 consecutive hours per day for 5 of 6 days reviewed (Dates 02/01/25, 02/02/25, 02/09/25, 03/01/25, and 03/02/25). Findings included: Review of the daily nurse staffing sheets and associated time clock reports for the period 01/01/25 through 03/31/25 revealed the facility did not have the required RN coverage on the following dates: 02/01/25, 02/02/25, 02/09/25, 03/01/25, and 03/02/25. During an interview on 08/27/25 at 1:52 PM, the Central Supply Manager revealed she handled the Skilled Nursing staff schedules in January 2025 through March 2025. She stated there were times when no RN was scheduled daily from 8 to 12 hours, although she could not recall specific dates. The Central Supply Manager stated that when there was no RN scheduled for at least 8 consecutive hours, she notified the Former Administrator, and the Former Administrator handled the situation from that point. A telephone interview with the Former Administrator on 08/27/25 at 2:49 PM revealed she was employed at the facility in January 2025 through mid-to-late March 2025 and was aware that there were times when an RN was not scheduled for 8 consecutive hours on weekends. She stated she had a Minimum Data Set (MDS) Nurse who was an RN, work one weekend, and the Treatment Nurse, who was also an RN, work the opposite weekend to ensure there was RN coverage for 8 consecutive hours. The Administrator stated after she implemented having the MDS Nurse and Treatment Nurse working on alternating weekends she was not aware of any issues with not having an RN scheduled for 8 hours a day. She stated she could not recall the date when she implemented placing the 2 RNs on alternating weekends. During an interview with the Regional Director of Clinical Operations on 08/27/25 at 3:54 PM she acknowledged the facility did not have documentation of	F0727	Continued from page 1 If any RN that is scheduled is unable to fulfill the full 8 hours, the Director of Nursing or licensed nurse will assign another RN or administrative nurse to fulfill the requirement. The schedule and daily nurse staffing sheets will be updated and verified by the Director of Nursing and/or designee daily x four weeks, every other day for the next four weeks, and weekly x four weeks to verify that eight hours of registered nursing coverage is occurring daily. Any discrepancies will be reported to the Executive Director immediately, education will occur, and the schedule will be rectified the day of by an RN or administrative nurse on staff appointed by the Director Nursing or licensed nurse to fill the required 8 hrs. Any new staff hired involved in the schedule will be in-served/educated on the process before being able to manage any part of the schedule. The plan will be taken to QAPI meeting by the Director of Nursing, all audits will be reviewed by the IDT team monthly. PBJ will be checked monthly to ensure that every day has posted RN coverage. All corrective actions and education will be completed by 9/18/25.	

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F0727 SS = F	Continued from page 2 the required RN coverage on 02/01/25, 02/02/25, 02/09/25, 03/01/25, and 03/02/25. She stated she thought having the MDS Nurse and Treatment Nurse alternate weekends addressed the lack of RN coverage on weekends but there may have been times when there were call-outs or staff worked in a sister facility. The Regional Director of Clinical Operations stated with the change in nursing administration in May 2025 nurse staffing had improved and the facility had sufficient RN staff to ensure required RN coverage was met consistently.	F0727		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors.	F0732	The plan of correction is for the deficient practice. The plan should address the processes that lead to the deficiency. The facility failed to have the staffing sheets accurately posted. Residents residing in the facility have the potential to be affected by the deficient practice. The Director of Nursing or licensed nurse will review daily staffing sheets to ensure accuracy and that they are updated throughout the shifts. The staffing sheet will be updated in real time and the scheduler and/or supervisors will adjust with any corrections as needed through the shift. Education will be given to anyone that is involved in the scheduling process to include the Director of Nursing, Assistant Director of Nursing, and all supervisors. This will include the information regarding the regulation of mandatory 8hrs per day registered nurse coverage in a skilled nursing facility and staffing sheet posting accuracy. All staff involved in scheduling will be educated on the process by 9/12/25. Any new staff hired involved in scheduling will be in-serviced on the procedure before they are able to manage any scheduling details. The staffing sheets are to be collected and checked by the Director of Nursing or licensed nurse 5x weekly x 4 weeks, then 3x weekly x 4weeks and then 1x weekly x 4 weeks. Any corrections will be reported to the Executive Director and training will be given. The plan of correction and audits will be taken to QAPI by the Director of Nursing or licensed nurse for monthly review. PBJ will also be checked monthly for accuracy of hours being recorded. All corrective actions and education will be completed by 9/18/25.	09/18/2025

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F0732 SS = C	Continued from page 3 §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure daily nurse staffing sheets accurately reflected the nursing staff who worked for 4 of 6 days reviewed (02/01/25, 02/02/25, 02/09/25, and 03/02/25). Findings included: Review of the facility's daily nurse staffing sheet revealed underneath the facility's name was a space to specify the date along with columns to specify the resident census, number of staff and hours worked for Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) for each 12-hour shift, 7:00 AM to 7:00 PM (day shift) and 7:00 PM to 7:00 AM (night shift). a. The daily nurse staffing sheet dated 02/01/25 revealed on day shift there was 1 RN and 3 LPNs. The nursing staff time clock report for 02/01/25 revealed there were 3 LPNs and no RN. b. The daily nurse staffing sheet dated 02/02/25 revealed on day shift there was 1 RN and 3 LPNs. The nursing staff time clock report for 02/02/25 revealed there were 3 LPNs and no RN. c. The daily nurse staffing sheet dated 02/09/25 revealed on day shift there was 1 RN and 3 LPNs. The nursing staff time clock report for 02/02/25 revealed there were 3 LPNs and no RN. d. The daily nurse staffing sheet dated 03/02/25 revealed on day shift there was no RN and 3 LPNs. The nursing staff time clock report for 03/02/25 revealed there was an RN for 3 hours and 3 LPNs. An interview with the Assistant Director of Nursing (ADON) on 08/27/25 at 12:56 PM revealed since beginning employment in May 2025 she was responsible for completing daily nurse staffing sheets. She stated on	F0732		

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F0732 SS = C	Continued from page 4 weekends the nursing supervisor was responsible for updating the daily nurse staffing sheets to reflect call-outs and/or schedule changes. The weekend nursing supervisor was unavailable for interview during the survey. An interview with the Central Supply Manager on 08/27/25 at 1:52 PM revealed in February 2025 and March 2025 she was responsible for completing the daily nurse staffing sheets. She stated on Fridays she would complete and give the receptionist the daily nurse staffing sheets for Saturday, Sunday, and Monday and the receptionist would fill in the census and post the staffing each weekend day. She stated it was the responsibility of the nursing staff working the weekend to update the daily staffing sheets to reflect information such as call-outs and/or schedule changes. An interview with the Administrator on 08/27/25 at 4:18 PM revealed the ADON was responsible for posting and updating daily nurse staffing sheets throughout the week and the weekend nursing supervisor was responsible for posting and updating the sheets on weekends. She stated she expected the daily nurse staffing sheets to be updated as needed to reflect the correct number and hours of nursing staff that worked each shift.	F0732		
F0808 SS = D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews with the Registered Dietitian (RD) and staff, the facility failed to follow the physician's diet order to provide double portions (Resident #10) and nutritional supplements (Resident #54) for 2 of 4 residents reviewed for nutrition (Resident #10 and Resident #54). Findings included:	F0808	Residents residing in the facility that require additional recommendations or specified diets have the potential to be affected by the deficient practice. It is the practice of the facility to serve therapeutic diets as prescribed by the attending physician and to provide double portions and nutritional supplements as ordered. Resident #10 was provided with double portions of protein, starch, and vegetables for all meals after the review on 8/24/25. The food service Director performed an audit on tray cards and physician diet orders on current residents to reflect serving portions, this was completed on 9/12/25. The Nutritional supplement Magic cup was ordered, and Resident #54 was provided with magic cup with meal tray daily after 8/26/25. The Food Service Director performed an audit on meal tickets and physician dietary orders on current residents to identify supplement orders needing to be on the meal ticket the audit was completed on 9/12/25. RD educated dietary staff on 08/29/2025 on the following: Resident diet order and portions and notifying charge nurse when a	09/18/2025

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F0808 SS = D	Continued from page 5 1. Resident #10 was admitted to the facility 04/28/25 with diagnoses including diabetes and malnutrition. Review of Resident #10's physician orders revealed an order dated 05/09/25 for a mechanical soft diet (a texture modified diet which restricts foods that are difficult to chew or swallow) and double portions. Resident #10's nutrition care plan initiated 05/16/25 revealed he had a nutritional problem related in part to malnutrition and diabetes. Interventions included having the Registered Dietitian (RD) evaluate and make diet changes as needed and providing and serving Resident #10's diet as ordered. Review of the quarterly Minimum Data Set (MDS) assessment dated 08/03/25 revealed Resident #10 was severely cognitively impaired and received a mechanically altered diet. The MDS assessment further indicated he had a weight loss of 5% or more in the last month or weight loss of 10% or more in the last 6 months. An observation of Resident #10's lunch meal ticket on 08/24/25 at 11:59 AM revealed he was to receive a mechanically altered diet with double portions. An observation of Resident #10's meal tray at the same date and time revealed he received a large serving of mashed potatoes and cooked carrots and one small scoop of beef on his plate. An interview with Nurse Aide #1 on 08/24/25 at 11:59 AM revealed she set-up Resident #10's meal tray and did not notice he did not receive a double portion of beef. An observation of Resident #10's lunch meal with Cook #1 on 08/24/25 at 12:00 PM revealed he did not receive a double portion of beef on his meal tray. She stated double portions were considered to be 2 servings of a food item. Cook #1 stated she was working as a dietary aide on 08/24/25 and was responsible for checking meal trays for accuracy and she overlooked providing Resident #10 with a double portion of meat. An interview with the Dietary Manager on 08/27/25 at 9:16 AM revealed he expected residents to receive double portions as ordered. A telephone interview with the Registered Dietitian (RD) on 08/27/25 at 10:39 AM revealed she made a recommendation for Resident #10 to receive double portions as an intervention for weight loss. She stated she expected residents to receive double portions as ordered.	F0808	Continued from page 5 dietary supplement is not available. All dietary staff education completed on 8/29/25. All new dietary staff will be in-serviced on resident diet order and portions and notifying charge nurse when a dietary supplement is not available. Food service Director and/or dietary personnel to perform 5 random audits weekly of diet trays x 4 weeks; 3 times weekly for 4 weeks and 1-time weekly x 4 weeks to insure all items are present. Any issues with the audits will be corrected immediately and training will be given by the food service manager. The Executive Director will review the results of the audits for trends and will report the findings to the QAPI committee for further recommendations, as appropriate. Completion date 9/18/25	

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F0808 SS = D	Continued from page 6 An interview with the Administrator on 08/27/25 at 4:25 PM revealed she expected residents to receive double portions as ordered. 2. Resident #54 was admitted to the facility 11/18/16 with a diagnosis of stroke. Resident #54's nutrition care plan last revised 04/10/25 revealed she was at risk for weight fluctuation related to her current health status and interventions included providing assistance with meals as needed and providing supplements as ordered. The quarterly Minimum Data Set (MDS) assessment dated 08/02/25 revealed Resident #54 was severely cognitively impaired and did not have weight loss. Review of Resident #54's physician orders revealed an order dated 08/13/25 for a frozen nutritional supplement two times a day to promote weight stability. An observation of Resident #54's lunch meal ticket on 08/24/25 at 12:33 PM revealed she was to receive a 4-ounce frozen nutritional treat. An observation of Resident #54's meal tray at the same date and time revealed the frozen nutritional treat was not provided with her lunch meal. An interview with Cook #1 on 08/24/25 at 12:43 PM revealed the kitchen was out of frozen nutritional treats and she was unsure how long the facility had been out of the supplement. An additional observation of Resident #54's lunch meal ticket on 08/25/25 at 12:33 PM revealed she was to receive a 4-ounce frozen nutritional treat. An observation of Resident #54's meal tray at the same date and time revealed the frozen nutritional treat was not provided with her lunch meal. An interview with the Dietary Manager on 08/27/25 at 9:16 AM revealed dietary staff usually notified him if the facility ran out of nutritional supplements and he followed-up with the resident's nurse, but he had been out of town on 08/24/25 and 08/25/25. He stated in his absence, dietary staff should have notified the resident's assigned nurse that the frozen nutritional treat was unavailable. A follow-up interview with Cook #1 on 08/27/25 at 10:35 AM revealed she would usually notify the Dietary Manager when the facility was out of frozen nutritional treats, but he was unavailable and she did not notify	F0808		

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F0808 SS = D	Continued from page 7 Resident #54's nurse that the supplement was unavailable. A telephone interview with the Registered Dietitian (RD) on 08/27/25 at 10:39 AM revealed she expected residents to receive nutritional supplements as ordered. She stated if the facility ran out of ordered supplements, dietary staff should notify nursing staff so orders for an appropriate substitute could be obtained. An interview with the Administrator on 08/27/25 at 4:25 PM revealed she expected residents to receive nutritional supplements as ordered and if they were unavailable, then nursing staff should have been notified so an appropriate substitute could be ordered.	F0808		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews the facility failed to discard expired milk in 1 of 1 walk-in cooler; label and date a food item in 1 of 1 walk-in freezer; label and date open food items and store food off the floor in 1 of 1 dry storage	F0812	It is the practice of the facility to store, prepare, distribute and serve food in accordance with professional standards for food service safety. All residents have the potential to be affected. The expired box of 8-ounce cartons of 2% milk with a use-by date of 08/21/25 milk in the walk-in cooler was discarded on 8/24/2025. The unlabeled and undated bag of boneless chicken breasts sitting on a shelf in walk in freezer was discarded on 8/24/2025. The Dry Storage room: The open and undated bag of powdered sugar sitting on a shelf was discarded on 8/24/2025. The open and undated bag of graham crackers sitting on a shelf was discarded on 8/24/2025.The three boxes of nutritional supplement stored on the floor were removed from the floor and stored off the floor on 08/24/2025. The ice machine build-up of gray debris on the left vent in the dining room was cleaned accordingly on 08/25/2025. The 500/600 hall nourishment room refrigerator was deep cleaned on 08/25/2025. The Food Service Director reviewed food storage areas in the facility and any items found to be unlabeled, expired or outside of manufacture's storage guidelines for use were disposed of on 8/27/2025. RD educated dietary staff on labeling and dating food, disposing of any items unlabeled, expired, or outside of manufacture's guidelines for use and cleaning procedures on 8/29/2025. All new dietary staff will be educated on the practice of label and dating any items opened, throwing out expired items, and the cleaning process of equipment before being able to start working in the kitchen. The Food Service Director and/or dietary personnel will perform audits of food storage areas 5 times weekly x4 weeks, 3 times weekly x 4 weeks and 1-time weekly x 4 weeks to review items that there are no items unlabeled, expired or outside of	09/18/2025

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F0812 SS = E	Continued from page 8 room; maintain a clean and sanitary ice machine for 1 of 2 ice machines; and maintain a clean and sanitary refrigerator in 1 of 2 nourishment rooms (500/600 hall nourishment refrigerator). Findings included: 1. An initial observation of the walk-in cooler on 08/24/25 at 9:22 AM revealed a 3/4 full box of 8-ounce cartons of 2% milk with a use-by date of 08/21/25. An interview with the Dietary Manager on 08/27/25 at 9:16 AM revealed the milk should have been used or discarded on or before the use-by date. He stated all dietary staff were responsible for checking for and removing expired food and beverage items. An interview with the Administrator on 08/27/25 at 4:25 PM revealed she expected all food and beverages to be used or discarded on or before the use-by date. 2. An observation of the walk-in freezer on 08/24/25 at 9:28 AM revealed an unlabeled and undated bag of boneless chicken breasts sitting on a shelf. An interview with the Dietary Manager on 08/27/25 at 9:16 AM revealed he expected all food items to be labeled and dated. An interview with the Administrator on 08/27/25 at 4:25 PM revealed she expected all food items to be labeled and dated. 3. An observation of the dry storage room on 08/24/25 at 9:32 AM revealed the following: a. an open and undated bag of powdered sugar sitting on a shelf b. an open and undated bag of graham crackers sitting on a shelf c. three boxes of nutritional supplement stored on the floor An interview with the Dietary Manager on 08/27/25 at 9:16 AM revealed all opened food items should be labeled and dated by the staff member opening the items and no stock should be stored on the floor. An interview with the Administrator on 08/27/25 at 4:25 PM revealed she expected all open food items to be labeled and dated, and no stock should be stored on the floor.	F0812	Continued from page 8 manufactures guidelines for use. Any discrepancies will be corrected immediately, and education and/or corrective action will follow. The Executive Director will review the results of the audits for trends and will report the findings to the QAPI committee for further recommendations, as appropriate. Items to be completed by 9/18/25.	

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F0812 SS = E	Continued from page 9 4. An observation of the ice machine in the dining room on 08/24/25 at 9:40 AM revealed a build-up of gray debris on the left vent. An interview with Cook #1 on 08/26/25 at 11:52 AM revealed maintenance was supposed to clean the ice machine. An interview with the Maintenance Director on 08/27/25 at 8:34 AM revealed a contract company de-limed and de-scaled the ice machine quarterly and he was responsible for ensuring the outside of the ice machine was clean. He stated he cleaned the ice machine if dietary staff made him aware of any areas that were visibly dirty, and he had not been informed of any concerns with the ice machine. An interview with the Administrator on 08/27/25 at 4:25 PM revealed she expected the ice machine to be clean and free of debris. 5. An observation of the 500/600 hall nourishment room refrigerator on 08/24/25 at 11:17 AM revealed a large area of a dried white substance with cardboard stuck in the center on the middle shelf of the refrigerator. An interview with the Dietary Manager on 08/27/25 at 9:16 AM revealed he expected dietary staff to clean nourishment room refrigerators when they noticed they were dirty. An interview with the Administrator on 08/27/25 at 4:25 PM revealed she expected the nourishment room refrigerators to be checked daily for cleanliness.	F0812		
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:	F0880	Residents residing in the facility have the potential to be affected by the deficient practice. The facility failed to follow their infection control policy and procedure to implement Enhanced Barrier Precautions (EBP) for a resident with a diabetic foot ulcer (Resident #10) and failed to wear a protective gown during tracheostomy care (a surgical opening in the neck), and a dressing change for an endoscopic gastrostomy (feeding tube) for a resident on EBP (Resident #3). Additionally, the facility failed to follow their hand hygiene policy and procedure to remove gloves and perform hand hygiene when a soiled dressing was changed from around a feeding tube (Resident #3). Any residents on enhanced barrier precautions have the potential to be affected. The Director of Nursing (DON), Infection Preventionist (IP) and/or licensed nurse will conduct facility a wide education on hand washing and enhanced barrier	09/18/2025

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F0880 SS = D	Continued from page 10 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F0880	Continued from page 10 precautions. All residents charts will audited to ensure that Enhanced Barrier Precautions (EBP) criteria is met and required, then signage, orders and precautions will be initiated and communicated to the Interdepartmental Team (which includes Social Work, Accounts Payable, Director Of Nursing, Assistant Director of Nursing, Maintenance, Business Office Manager, Unit Manager, Admissions, Marketing, Environmental Services Director, Certified Dietary Manager, Infection Preventionist, Wound Nurse, Minimum Data Set Nurses, and Health Information Manager) daily. The chart audit will be completed by 9/18/25. The Director of Nursing (DON), Infection Preventionist (IP) and/or licensed nurse will provide education to all staff regarding hand hygiene and all direct care staff regarding EBP. Education will be completed by 9-18-25. *Any staff member who hasn't completed education by 9-18-25 will be removed from the schedule and unable to work until education is completed. Enhanced Barrier precautions and hand washing between procedures will be audited 5x per week x 4weeks, three (3) times per week for four (4) weeks; then one (1) time a week for four (4) weeks. The Executive Director (ED) and/or Director of nursing will be notified immediately and will provide education for incidents of non-compliance. All audits will be brought to QAPI by the Director of Nursing, Infection prevention nurse and/or licensed nurse for review.	

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F0880 SS = D	Continued from page 11 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow their infection control policy and procedure to implement Enhanced Barrier Precautions (EBP) for a resident with a diabetic foot ulcer (Resident #10) and failed to wear a protective gown during tracheostomy care (a surgical opening in the neck), and a dressing change for an endoscopic gastrostomy (feeding tube) for a resident on EBP (Resident #3). Additionally, the facility failed to follow their hand hygiene policy and procedure to remove gloves and perform hand hygiene when a soiled dressing was changed from around a feeding tube (Resident #3). The deficient practice occurred for 1 of 3 staff members observed for infection control practices (Treatment Nurse). The findings included: The facility's EBP policy last revised on 4/22/25 revealed EBP was used as an additional MDRO (multidrug-resistant organism) mitigation strategy for any resident who met the criteria during high-contact resident care activities. Examples that met criteria for the use of EBP included chronic wounds and listed diabetic foot ulcers as a chronic wound. The policy's definition of high-contact resident care activities that required glove and gown use included wound care of any skin opening that required a dressing. The policy included the facility had discretion in using EBP for residents who do not have a chronic wound. The policy indicated EBP should not be used for residents who are infected or colonized with an MDRO for which contact precautions were recommended in Appendix A of the Center for Disease Control and Prevention (CDC) guideline for isolation precautions. The CDC Appendix A guideline for a pressure ulcer with a minor or limited infection and if a dressing covered and contained drainage was to use standard precautions. 1. An observation of Resident #10's wound care for a diabetic foot ulcer performed by the Treatment Nurse was conducted on 8/25/25 at 1:58 PM. There was no dressing in place at the time of the observation, and	F0880		

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F0880 SS = D	Continued from page 12 the wound did not have visible drainage. The Treatment Nurse used an alcohol-based hand sanitizer and put on a pair of gloves prior to care. The Treatment Nurse wiped the ulcer with gauze moistened with normal saline, applied a petroleum infused dressing, and covered the ulcer with a protective dressing. The Treatment Nurse did not wear a protective gown during Resident #10's wound care for the diabetic ulcer on the right foot. During an interview on 8/25/25 at 3:44 PM, the Treatment Nurse revealed the old dressing was removed prior to the observation for assessment by the Wound Care Nurse Practitioner. The Treatment Nurse was asked if EBP were used for Resident #10 during care for the diabetic foot ulcer. The Treatment Nurse stated it was her understanding if the wound was 3 months old EBP were used and if not, she did not wear a protective gown during wound care for Resident #10's diabetic foot ulcer. An interview was conducted with Director of Nursing (DON) in the presence of the Infection Preventionist on 8/27/25 at 8:30 AM and at 9:18 AM. It was explained the Treatment Nurse did not wear a protective gown while she provided wound care for Resident #10's diabetic foot ulcer because EBP were not implemented. The DON confirmed EBP were not implemented for Resident #10 and only used for wounds that were present for 3 months or longer. The DON stated in the policy the facility had the discretion to use EBP for any resident who did not have a chronic wound. The DON stated she did not consider Resident #10's diabetic ulcer as a chronic wound since it had not been present for 3 months. The DON stated the facility's EBP policy included the CDC Appendix A and based on the guidance for pressure ulcers she had determined standard precautions should be used for Resident #10. During an interview on 8/27/25 at 3:56 PM, it was explained to the Administrator, EBP were not implemented for Resident #10 who had a diabetic foot ulcer, and during wound care the Treatment Nurse did not wear a protective gown when the wound was cleaned, and a new dressing applied. The Administrator stated based on the facility's EBP policy the examples of chronic wounds included diabetic foot ulcers and should be implemented for Resident #10 and followed during wound care. 2. Review of the facility's Enhanced Barrier policy last revised 04/22/25 read in part as follows: "Policy: The facility should use Enhanced Barrier	F0880		

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F0880 SS = D	Continued from page 13 Precautions (EBP) as an additional MDRO [multidrug-resistant organisms] mitigation [prevention] strategy for residents that meet the following criteria, during high contact resident care activities; EBP are indicated for residents with any of the following: Indwelling medical device examples includ[ing] feeding tubes and tracheostomies (a surgical opening in the neck that allows breathing). EBP should be used for any residents who meet the above criteria. Enhanced Barrier Precautions (EBP)-refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Examples of high-contact resident care activities requiring gown and glove use include device care or use: feeding tube [and] tracheostomy/ventilator." An observation of Resident #3's door on 08/25/25 at 2:45 PM revealed signage indicating Resident #3 was on EBP and a shelf was hanging on the door containing gowns and gloves. A continuous observation of the Treatment Nurse on 08/25/25 from 2:47 PM through 2:58 PM revealed she entered Resident #3's room, performed hand hygiene with alcohol-based hand rub (abhr), donned (put on) gloves, opened the tracheostomy care kit and added normal saline (salt water), removed the inner cannula (tube) and discarded it in the trash, removed her gloves and performed hand hygiene with abhr, donned sterile gloves, inserted a new inner cannula into Resident #3's tracheostomy, removed the soiled gauze from the tracheostomy, removed her gloves, performed hand hygiene with abhr, donned clean gloves, cleaned around the tracheostomy with normal saline moistened gauze, removed her gloves, performed hand hygiene with abhr, donned clean gloves, applied a clean gauze to the tracheostomy, removed her gloves, and performed hand hygiene with abhr. The Treatment Nurse did not don a gown while providing tracheostomy care. An additional continuous observation of the Treatment Nurse on 08/25/25 at 2:59 PM through 3:02 PM revealed she performed hand hygiene with abhr, donned clean gloves, entered Resident #3's room, removed the soiled gauze from Resident #3's feeding tube, cleaned around the feeding tube with normal saline moistened gauze, dried the area around the feeding tube with gauze, applied clean gauze around the feeding tube, removed	F0880		

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F0880 SS = D	Continued from page 14 her gloves, performed hand hygiene with abhr, and exited Resident #3's room. The Treatment Nurse did not don a gown while providing feeding tube care. An interview with the Treatment Nurse on 08/25/25 at 3:04 PM revealed she should have donned a gown when providing tracheostomy care and feeding tube care and she did not because it was an oversight. An interview with the Director of Nursing (DON) on 08/25/25 at 3:18 PM revealed she expected nursing staff to follow EBP when providing as indicated. An interview with the Administrator on 08/27/25 at 4:25 PM revealed she expected staff to follow EBP when providing care as indicated. 3. Review of the facility's hand hygiene policy last reviewed 07/07/25 read in part as follows: "Policy: The facility has adopted CDC [Centers for Disease Control] Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings for indications for hand hygiene that are generally consistent with the WHO [World Health Organization] 5 moments for hand hygiene. Definitions: Alcohol-based hand rub (ABHR) refers to a 60-95 percent ethanol [alcohol] or isopropyl alcohol-containing preparation base designed for application to the hands to reduce the number of viable micro-organisms. Hand hygiene refers to a general term that applies to hand washing, antiseptic handwash, and alcohol-based hand rub. Procedure: Associates perform hand hygiene (even if gloves are used) in the following situations: a. before and after contact with the resident; b. after contact with body fluids; c. after removing personal protective equipment (gloves, gown, eye protection, facemask) Introduction: An alcohol-based hand rub is appropriate for decontaminating the hands when moving from a contaminated body site to a clean body site during patient care and after contact with bodily fluids.	F0880		

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F0880 SS = D	Continued from page 15 5 Moments for Hand Hygiene 1. before touching a patient 2. before a clean procedure 3. after body fluid exposure risk 4. after touching a patient 5. after touching patient surroundings." A continuous observation of the Treatment Nurse on 08/25/25 at 2:59 PM through 3:02 PM revealed she performed hand hygiene with abhr, donned clean gloves, entered Resident #3's room, removed the soiled gauze containing a small amount of white drainage from Resident #3's feeding tube, cleaned around the feeding tube with normal saline moistened gauze, dried the area around the feeding tube with gauze, applied clean gauze around the feeding tube, removed her gloves, performed hand hygiene with abhr, and exited Resident #3's room. The Treatment Nurse did not remove her gloves and perform hand hygiene after removing the soiled gauze and before cleaning around the feeding tube. An interview with the Treatment Nurse on 08/25/25 at 3:04 PM revealed she would not remove her gloves and perform hand hygiene after removing soiled gauze and before cleaning around the feeding tube unless her gloves were visibly soiled. An interview with the Director of Nursing (DON) on 08/25/25 at 3:18 PM revealed she expected nursing staff to remove their gloves and perform hand hygiene after removing soiled gauze around a feeding tube. An interview with the Administrator on 08/27/25 at 4:25 PM revealed she expected staff to remove their gloves and perform hand hygiene when moving from a dirty task to a clean task.	F0880		