STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175350	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH , MARYSVILLE, Kansas, 66508

(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
F0000	INITIAL COMMENTS The following citations represent the findings of a health resurvey and complaint investigations 1498608, 1498616, and 2594166. The 2567 was sent electronically on 09/09/25.	F0000		
F0550 SS = E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F0550		

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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F0550 SS = E	Continued from page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 72 residents. The sample included 18 residents. Based on observation, interview, and record review, the facility failed to promote care in a manner to maintain and enhance dignity and respect when staff used Styrofoam plates and bowls instead of regular dinnerware for meal service. This placed the residents of the facility at risk for impaired dignity. Findings included: - On 08/24/25 at 12:30 PM, observation during the lunch meal service revealed that staff provided Styrofoam plates for meatloaf, mashed potatoes, and carrots, and used Styrofoam bowls for the strawberry cake. On 08/25/25 at 08:45 AM, observation during the breakfast meal service revealed that staff provided Styrofoam plates for scrambled eggs, toast, and either sausage or bacon, and provided Styrofoam bowls for cereal. On 08/24/25 at 12:55 PM, Dietary Staff (DS) BB stated that the facility used the Styrofoam plates and bowls because the kitchen was short-staffed and did not have enough help to clean the dishes. On 08/26/25 at 10:30 AM, Administrative Nurse D verified that staff should not have used Styrofoam plates and bowls for daily meal service. Administrative Nurse D stated she verified with dietary staff that the reason they use them for the two meals was due to a lack of staff. The facility's "Dining Room Standards" policy, dated 2020, documented staff would ensure that an attractive, cheerful dining room was maintained with comfortable sound, lighting, furnishings, temperature, and adequate space. The policy documented that single-use disposable dining ware was not permitted except for emergencies.	F0550		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	F0558		

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F0558 SS = D	Continued from page 2 §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: The Facility had a census of 77 residents. The sample included 18 residents, with one reviewed for the environment. Based on observation and interview, the facility failed to provide accommodation of needs for one sampled resident, Resident (R) 66, who had a call light on her wall that was unreachable from her bed. This deficient practice placed R66 at risk for preventable accidents and injuries. Findings included: - On 08/24/25 at 10:30 AM, observation revealed R66 sat in a wheelchair in her room. R66's call light hung on the wall. The call light was unreachable by R66 when she was in bed. On 08/24/25 at 03:00 PM, observation revealed R66 sat in a wheelchair in her room. R66's call light hung on the wall and was unreachable to R66 when she was in bed. On 08/25/25 at 03:08 PM, Certified Nurse's Aide (CNA) MM stated the resident liked to propel herself up and down the halls in her wheelchair and sit in the hall and dining room area. On 08/24/25 at 02:00 PM, Licensed Nurse (LN) I stated the resident was mobile in her wheelchair and had recently had a total knee replacement and was getting therapy, but could not safely ambulate independently. LN I stated every resident should have an accessible call light. On 08/24/25 at 03:15 PM, Administrative Nurse E stated R66 had moved from a room down the hall about one month ago. Administrative Nurse E had not known R66 did not have a call light bedside her bed. Administrative Nurse E verified that the resident should have a permanent call light to access from their bed, and R66 did not have access to one. On 08/26/25 at 10:30 AM, Administrative Nurse D verified that a resident's call light should be accessible to the resident in bed and should not be across the room from the bed.	F0558		

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F0558 SS = D	Continued from page 3 The facility's "Call lights: Accessibility and Timely Response“ policy, dated 09/09/20, documented the facility would ensure it was adequately equipped with a call light at each resident’s bedside and bathing area to allow residents to call for assistance, and the call lights would directly relay to a staff member or centralized location to ensure appropriate response. Staff would be educated on the proper use of the resident call light system, including how the system works, and ensure residents' access to the call light. The policy documented with each staff interaction in the resident’s room or bathroom, the staff would ensure the call light was within reach of the resident and secured.	F0558		
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility	F0582		

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F0582 SS = D	Continued from page 4 must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 77 residents. Based on record review and interview, the facility failed to provide Resident (R) 9, R11, and R12, or their representative, the completed Skilled Nursing Facility Advanced Beneficiary Notices (ABN) form 10055. This placed the resident at risk of uninformed decisions about their skilled services. Findings included: - The "Medicare ABN form 10055" informed the beneficiary that Medicare may not pay for future skilled therapy services. The form included an option for the beneficiary to receive specific services, the cost listed, and bill Medicare for an official decision on payment. The form stated 1) "I understand if Medicare does not pay, I will be responsible for payment, but can make an appeal to Medicare," (2) "I want to receive therapy listed, but do not bill Medicare, I am responsible for payment for services," (3) "I do not want the listed services." This placed the residents at risk of uninformed decisions about their skilled services. Review of R9, R11, and R12's Part A Medicare discharge papers revealed the facility had not provided the residents with the Medicare ABN form 10055, disclosing the cost of continuing skilled services. On 08/26/25 at 12:15 PM, Administrative Staff A	F0582		

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F0582 SS = D	Continued from page 5 verified that the facility lacked documentation that the ABN form 10055 was provided to the discharged residents. The facility's "Advanced Beneficiary Notices" policy, dated 11/01/19, stated the facility shall inform Medicare beneficiaries of his or her potential liability for payment. A liability notice shall be issued to Medicare beneficiaries upon admission or during a resident's stay, before the facility provides an item or service that is usually paid for by Medicare, but may not be paid for in a particular instance because it is not medically reasonable and necessary, or custodial care. The facility shall use the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), Form CMS- I 0055. To ensure that the resident, or representative, has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided within two days of the last anticipated	F0582		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as	F0657		

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F0657 SS = D	Continued from page 6 requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 77 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to revise the care plan for one sampled resident, Resident (R) 47, which included interventions for antihypertensive (a class of medication used to treat high blood pressure) medications. This placed the residents at risk for physical decline, other related complications, and at risk for unnecessary medications. Findings included: - The Electronic Medical Record (EMR) for R47 had diagnoses of pulmonary hypertension (high blood pressure in the arteries of the lungs), atrial fibrillation (rapid, irregular heartbeat), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and dementia with behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion). The" Quarterly Minimum Data Set" (MDS) dated 06/11/25, documented R47 had moderately impaired cognition. R47 required partial assistance with oral hygiene, toileting hygiene, upper body dressing, personal hygiene, mobility, transfers, and ambulation. The MDS documented R47 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), and diuretic (a medication used to promote the formation and excretion of urine) medications daily. R47's "Care Plan" dated 06/24/25, initiated on 03/10/23, documented R47 received medications that had black box warnings (BBW - the highest safety-related warning that medications can have assigned by the Food and Drug Administration). The care plan further directed staff to administer medications as ordered, refer to the eMAR (electronic medication administration record), as medications that have a BBW were designated by a black box that would show the full warning. The care plan lacked further direction to staff regarding interventions related to antihypertension medications. The care plan further failed to provide direction to	F0657		

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F0657 SS = D	Continued from page 7 staff for R47's Metoprolol (an antihypertensive) medication. The" Physician's Order," dated 12/06/24, directed staff to administer Metoprolol ER (extended release), 25 milligrams (mg), by mouth, in the morning, for atrial fibrillation and hypertension. Hold the medication if systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was less than 100 millimeters of mercury (mmHg), or the heart rate (the number of times your heart beats in a minute) was less than 60 bpm (beats per minute). R47's "Medication Administration Record" (MAR) for July 2025 documented the following days R47 received the metoprolol when the heart rate was under the ordered parameters: 07/18/25 - 58 bpm 07/28/25 - 57 bpm 07/31/25 - 57 bpm R47's "MAR" for August 2025 documented the following days R47 received the metoprolol when the heart rate was under the ordered parameters: 08/05/25 - 59 bpm 08/07/25 - 58 bpm 08/08/25 - 58 bpm 08/20/25 - 59 bpm On 08/25/25 at 08:00 AM, R47 sat in her wheelchair in the dining room waiting for breakfast. On 08/26/25 at 09:10 AM, Certified Medication Aide (CMA) R stated R47 had two different hypertension medications, and each had different physician parameters. CMA R further stated that she did not usually worry about the heart rate; she focused on whether her blood pressure was out of parameters. On 08/26/25 at 09:18 AM, Licensed Nurse (LN) G stated that staff were to follow the physician's orders and hold the medication if the vital signs are out of the parameters. LN G further stated that the care plan should reflect that the hypertension medication R47 was prescribed could have side effects, and what staff should monitor for. LN G stated she would look at the	F0657		

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F0657 SS = D	Continued from page 8 care plan and update it with interventions for the hypertension medication. LN G stated she would provide education to the staff regarding the physician-ordered parameters. On 08/26/25 at 09:30 AM, Administrative Nurse F stated the medication should follow physician orders and notify the nurse if her heart rate was out of the physician-ordered parameters. Administrative Nurse F further stated that the care plan should reflect that the hypertension medication R47 was prescribed could have side effects, and what staff should monitor for. The facility's "Comprehensive Care Plan Revisions Upon Status Change" policy, dated 01/02/20, documented the comprehensive care plan would be reviewed and revised as necessary when a resident experienced a status change. The care plan would be updated with the new or modified interventions and modified as needed by the MDS Coordinator or other designated staff members. The Unit Manager or other designated staff member would communicate care plan interventions to all staff involved in the resident's care.	F0657		
F0679 SS = E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 77 residents. The sample included 18 residents. Based on observation, record review, and interviews, the facility failed to provide direct, interactive activities based on resident preferences on weekends. This deficient practice placed the affected residents at risk for decreased psychosocial well-being, boredom, and isolation. Findings Included: - A review of the facility's "Activity Calendars" for	F0679		

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F0679 SS = E	Continued from page 9 June 2025, July 2025, and August 2025 was completed. A review of the calendars indicated the residents only had access to an activity cart on Saturdays for self-led activities. The calendars noted that the residents were only provided a televised church service on Sundays. No other activities were listed for weekends for the residents. On 08/26/25 at 11:00 AM, the facility's Resident Council reported that the facility lacked consistent activities on the weekend due to the lack of staff present. The council reported that the activity director only worked weekdays. The council reported that direct care staff were already struggling to complete care and did not have enough staff to cover weekend activity groups. The council reported long call-light wait times and delayed care on weekends. On 08/25/25 at 10:21 AM, Certified Medication Aide (CMA) R stated that staff often would be busy completing care for the resident, and group activities may not always be completed on Saturdays and Sundays. On 08/25/25 at 11:24 AM, Activity Staff ZZ stated she only worked the weekdays, and direct care staff were expected to provide the scheduled activities on weekends. She also stated the residents could complete self-guided activities from the activities cart if they chose to. On 08/25/25 at 02:05 PM, Activities Staff ZZ provided a movie and popcorn group to the resident in the main dining room area. The facility's "Activities" policy (undated) indicated the facility would provide activities that meet the residents' needs and interests to support their physical, mental, and psychosocial well-being.	F0679		
F0689 SS = E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F0689		

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F0689 SS = E	Continued from page 10 This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 77 residents. The sample included 18 residents, with 13 reviewed for accidents. Based on observation, record review, and interview, the facility failed to secure potentially hazardous cleaning chemicals in a safe, locked area and out of reach of nine cognitively impaired, independently mobile residents. The facility additionally failed to provide adequate supervision and ensure Resident (R) 44's fall prevention interventions were followed, resulting in multiple non-injury falls. This placed the affected residents at risk for preventable accidents. Findings Included: - On 08/24/25 at 09:00 AM, an initial walkthrough of the facility was completed. An inspection of the main nurse's station area revealed a storage closet propped open by a cloth sling rope. An inspection of the storage closet revealed ten containers of purple disinfectant wipes on a shelf in the room. The containers contained the warning, "Keep out of reach of children, hazardous to humans, can cause eye irritation, harmful if swallowed." An inspection of the kitchenette across from the main dining hall revealed a purple disinfectant wipe container in an unlocked cabinet above the sink. The container contained the warning, "Keep out of reach of children, hazardous to humans, can cause eye irritation, harmful if swallowed." On 08/24/25 at 09:00 AM, Certified Medication Aide (CMA) R stated that cleaning chemicals were to be stored in a locked closet or drawer. On 08/26/25 at 11:30 AM, Administrative Nurse D stated that staff were expected to ensure chemical products were locked up after use. The facility's "Chemical Storage" policy, revised 01/2020, indicated the facility would ensure an environment free from potentially hazardous materials, chemicals, and equipment. - R44's "Medical Diagnosis" section within the Electronic Medical Record (EMR) noted diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, unsteadiness on feet, and a history of falls.	F0689		

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F0689 SS = E	Continued from page 11 R44's "Significant Change Minimum Data Set (MDS)" completed 08/04/25 revealed a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS noted no upper or lower extremity impairments. The MDS noted she required assistance from staff for toileting, bathing, personal hygiene, dressing, and transfers. The MDS noted she required partial to moderate assistance from staff while walking. The MDS noted she was at risk for falls and had a history of falls since the last assessment. R44's "Falls Care Area Assessment (CAA)" completed 08/18/25 indicated she was at risk for a decline in her activities of daily living (ADL) related to her decreased mobility, fatigue, and cognitive impairment. The CAA noted she had a history of falls. The CAA noted that a care plan was implemented to minimize the risks related to her fall history. R44's "Care Plan" initiated 10/17/20 indicated she was at risk of falls and altered ADLs related to her medical diagnoses. The plan noted she required non-skid footwear (10/17/20). The plan instructed staff to ensure her call light remained within reach (10/17/20). The plan instructed staff to provide appropriate lighting and ensure her room was free from clutter (10/17/20). The plan noted she was dependent on staff assistance for walking, toileting, transfers, bed mobility, personal hygiene, dressing, and bathing (11/15/23). The plan noted she had an unwitnessed fall and instructed staff to place a brightly colored bow on her front wheeled walker (01/30/24). The plan noted R44 had a non-injury fall on the enclosed patio of the secured unit on 09/04/24. The plan noted R44 had a non-injury fall while not wearing the appropriate non-skid footwear on 10/16/24. The plan noted that staff were re-educated on 03/12/25 to use a gait belt after a fall occurred during staff assistance. The plan noted she had a fall on 03/09/25 while wearing regular non-skid black socks. The plan noted that staff were to sign off under R44's medication administration report on each shift to ensure she had non-skid footwear. The plan noted she had a non-injury fall on 03/21/25 while not wearing non-skid socks. The plan noted that a sign was placed above her bed to remind staff to provide her with the appropriate socks. The plan noted R44 had an unwitnessed non-injury fall in front of the nurse's station on 06/03/25. The plan noted that staff were re-educated that R44 required supervision and/or touch assistance while ambulating. R44's EMR under "Progress Notes" revealed a "Communication with Providers" note completed on	F0689		

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F0689 SS = E	Continued from page 12 09/03/24. The note indicated staff were alerted by the secured unit's patio door alarm and found R44 outside on the patio floor of the enclosed patio. The note revealed R44 was assessed by nursing and brought back inside. On 08/26/25 at 07:41 AM, R44 slept in her bed. Her bed was in the lowest position with a fall mat on the floor next to her bed. R44's front-wheeled walker was positioned next to her recliner. R44's walker did not have a bright-colored ribbon tied to it. An inspection of her room revealed the "non-skid sock "signage was placed above her room's dresser behind a flowerpot. On 08/26/25 at 09:00 AM, Certified Medication Aide (CMA) R stated R44 used both her walker and wheelchair due to her decline in abilities and being placed on hospice care (end-of-life comfort care). She stated R44 was a fall risk due to her weakness and cognitive impairment. She stated staff were expected to ensure her fall interventions were followed and in place. CMA R stated the unit sometimes only had one or two staff members and often had difficulties providing supervision while performing care. On 08/26/25 at 12:24 PM, Administrative Nurse D stated all staff had access to review the care plan and ensure the interventions were in place. She stated new interventions would be discussed by the interdisciplinary team, and staff would be informed by the nurse. The facility's "Accidents and Supervision" policy (undated) indicated the facility promoted an environment that remains free from accident hazards. The policy indicated the facility appropriately assessed and implemented interventions to prevent falls and minimize complications if falls occurred.	F0689		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F0692		

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F0692 SS = D	Continued from page 13 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 77 residents. The sample included 18 residents, with one reviewed for hydration. Based on observation, record review, and interview, the facility failed to consistently monitor Resident (R) 70's physician-ordered fluid restriction. This placed the resident at risk of complications related to fluid overload. Findings included: - The Electronic Medical Record (EMR) for R70 documented diagnoses of chronic kidney disease, stage 4 (a progressive, long term condition where the kidneys gradually lose their ability to filter waste and excess fluid from the blood), peripheral autonomic neuropathy (a disorder of the peripheral nerves that control automatic bodily functions), edema (swelling, resulting from an excessive accumulation of fluid in the body tissues), and hypo osmolality (when there is an abnormally low concentration of solutes in the blood, often caused by too much water in the body). The "Quarterly Minimum Data Set" (MDS), dated 04/29/25, documented R70 had intact cognition. R70 required partial staff assistance with toileting hygiene, personal hygiene, mobility, transfers, and required set-up assistance with eating. The MDS further documented R70 had no functional impairment and was occasionally incontinent of bladder. The MDS documented R70 received diuretic (a medication to promote the formation and excretion of urine) medication daily. The "Annual MDS," dated 07/29/25, documented R70 had severely impaired cognition. R70 required partial staff assistance for toileting hygiene, personal hygiene, dressing, mobility, and transfers. R70 had no functional impairment, independent with eating, and received diuretic medication daily.	F0692		

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F0692 SS = D	Continued from page 14 R70's "Care Plan" dated 08/13/25, initiated on 11/13/23, documented R70 was on a 1800 cc (cubic centimeters) per 24 hours fluid restriction and directed staff to follow physician orders. The care plan further directed staff to document fluid intake every shift and monitor for signs and symptoms of dehydration (when the body loses more fluids than it takes in, resulting in a lack of water and electrolytes), report abnormal findings to the physician, and monitor for weight gain or loss. The update, dated 08/14/24, documented R70 would refuse the fluid restriction at times and was aware of the impact it could have on R70's health. The "Physician's Order," dated 04/16/25, directed a fluid restriction of 1800 cc per day and directed staff to provide 360 milliliters (ml) of fluids at breakfast, 240 ml of fluids at lunch and supper, and 320 ml of free fluids per shift. Nursing would provide 960 ml (320 ml per shift). The order further directed staff to administer free fluids of 320 ml at night, and for the nurses to include it in their documentation. This order was discontinued on 08/05/25 The" Physician's Order," dated 08/05/25, directed a fluid restriction of 1800 cc per day and directed staff to provide 360 milliliters (ml) of fluids at breakfast, 240 ml of fluids at lunch and supper, and 320 ml of free fluids per shift. Nursing would provide 960 ml (320 ml per shift). The order further directed staff to administer free fluids of 320 ml at night, and for the nurses to include it in their documentation. The staff were directed to notify the physician of non-compliance with the restriction and update the care plan. The "Treatment Administration Record" (TAR) for June 2025 lacked documentation of staff-monitored R4's fluid restriction on the following days: 06/07/25 - day shift 06/07/25 - evening shift 06/12/25 - evening shift 06/14/25 - evening shift 06/20/25 - evening shift 06/25/25 - evening shift 06/26/25 - evening shift	F0692		

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F0692 SS = D	Continued from page 15 The "Treatment Administration Record" (TAR) for July 2025 lacked documentation of staff-monitored R4's fluid restriction on the following days: 07/06/25 - evening shift 07/11/25 - day shift 07/17/25 - day shift 07/29/25 - day shift The "Treatment Administration Record" (TAR) for August 2025 lacked documentation of staff-monitored R4's fluid restriction on the following days: 08/07/25 - day shift 08/09/25 - evening shift 08/13/25 - evening shift On 08/25/25 at 11:45 AM, R70 had a pitcher with 450 ml of water on her bedside table. At 02:45 PM, the water pitcher had 300 ml of water in it. On 08/26/25 at 10:40 AM, Certified Nurse Aide (CNA) N stated she was unsure of the amount of fluid R70 was supposed to get on her shift, so she asked the kitchen before she provided R70 with any fluids at meals. On 08/26/25 at 09:18 AM, Licensed Nurse (LN) G stated that nursing staff worked with the kitchen on the fluid intake, and staff were to document per shift what the total intake of fluids was for that timeframe. On 08/26/25 at 09:40 AM, Administrative Nurse F stated she expected staff to follow the physician's orders for the fluid restriction and make sure the shift intake was properly documented in the medical record. The facility's "Fluid Restriction" policy, dated 2022, documented the fluid restriction would be followed in accordance with the physician's orders. The nurse would obtain and verify the physician's orders for the fluid restriction. An order written would include the breakdown of the amount of fluid per 24 hours to be distributed between the food and nutrition department and the nursing department. The intake would be recorded on the medication record or other format as per facility protocol. The fluid restriction distribution would take into consideration the amount of fluid to be given at mealtimes, snacks, and medication passes. Water would not be provided at the	F0692		

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F0692 SS = D	Continued from page 16 bedside unless calculated into the daily total fluid restriction.	F0692		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 77 residents. The sample included 18 residents, with two reviewed for dialysis (the process of removing waste products and excess fluid from the body when the kidneys are not able to adequately filter the blood). Based on observation, record review, and interview, the facility failed to ensure ongoing fluid restriction implementation for Resident (R) 4, who received dialysis treatment. This placed the resident at risk for complications and health decline. Findings included: - R4's Electronic Medical Record (EMR) recorded diagnoses of end stage renal disease (ESRD- a terminal disease of the kidneys), cerebrovascular accident (CVA- stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and hemiplegia (paralysis of one side of the body). R4's "Admission Minimum Data Set" (MDS), dated 07/31/25, recorded R4 had a Brief Interview for Mental Status (BIMS) score of six, which indicated severe cognitive impairment. The MDS recorded R4 required partial to moderate assistance for toilet hygiene, personal hygiene, and to shower/bathe self. The MDS further recorded R4 received dialysis treatment. R4's "Dialysis Care Plan," dated 08/0/25, documented R4 received dialysis three times a week on Mondays, Wednesdays, and Fridays. The care plan documented a fluid restriction of two liters and to follow the physician's order, and staff would use enhanced barrier precautions for dialysis. The "Physician Order," dated 07/25/25, documented R4	F0698		

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F0698 SS = D	Continued from page 17 would receive dialysis treatment three times a week on Monday, Wednesday, and Friday. The "Physician Order," dated 07/25/25, documented R4 received a renal diet, regular texture, regular consistency, and lacked an order for a fluid restriction. The “Standing Order” faxed to the physician, dated 07/25/25, documented the facility's standing orders and questioned the physician if he wanted the resident to be on a fluid restriction due to her dialysis status. The physician responded on 07/30/25, R4 should be on a 2000 milliliter (ml) fluid restriction, and the nurse noted the order. On 08/25/25 at 09:00 AM, observation revealed R4 sat in a wheelchair in the dining room. R4 had scrambled eggs, oatmeal, and one cup of water. Continued observation revealed R4 was dressed in street clothes and nicely groomed. On 08/25/25 at 10:30 AM, Administrative Nurse D verified R4 received dialysis three times a week on Monday, Wednesday, and Friday. Administrative Nurse D verified the resident was admitted to the facility on 07/25/25, and the physician did not have a fluid restriction. Administrative Nurse D verified a fax from the facility to the physician asking if the resident was to be on a fluid restriction, and the fax documented “Yes,” 2000 ml, signed on 07/30/25. The facility's "Fluid Restriction" policy, dated 2021, documented it was the policy of the facility to ensure that fluid restriction would be followed in accordance with the physician’s orders. The fluid restriction may be due to an underlying medical condition that may cause fluid buildup, such as congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid) or end-stage renal disease, in addition to an electrolyte (minerals that help keep the body’s fluid levels in balance, necessary to help the muscles, heart, and other organs work properly) imbalance disorder. Fluid restriction amounts could vary according to the resident’s condition and the physician’s judgment. The nurse would obtain the physician’s order for the fluid restriction and an order written to include the breakdown of the amount of fluid per 24 hours to be distributed between the food and nutritional department and the nursing department, and would be recorded on the medical record or other format as per facility protocol.	F0698		
F0725 SS = F	Sufficient Nursing Staff	F0725		

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F0725 SS = F	Continued from page 18 CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 58 residents. The sample included 14 residents. Based on observation, record review, and interviews, the facility failed to ensure sufficient staffing. This deficient practice placed the affected residents at risk for decreased psychosocial well-being, boredom, and delayed care. Findings Included: - A review of the facility's "Payroll-Based Journal" (PBJ - Staffing Data Report) from 04/01/22 through 03/31/25 indicated the facility triggered for "Excessively Low-Weekend Staffing" for Fiscal Year (FY) 2024 Quarter Four (07/01/24 - 09/30/24), FY 2025 Quarter One (10/01/24 - 12/31/24), and FY 2025 Quarter Two (01/01/25 - 03/31/25).	F0725		

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F0725 SS = F	Continued from page 19 On 08/25/25 at 10:21 AM, Certified Medication Aide (CMA) R stated that staff often would be busy completing care for the residents, and group activities may not always be completed on Saturdays and Sundays. CMA R stated the secured unit sometimes only had one or two staff members and often had difficulties providing supervision while performing care. (See citation F689) On 08/26/25 at 11:00 AM, the facility's Resident Council reported that the facility lacked consistent activities on the weekend due to the lack of staff present. The council reported that the activity director only worked weekdays. The council reported that direct care staff were already struggling to complete resident care, but would not have enough staff to cover weekend activity groups. The council reported long call-light wait times and delayed care on weekends due to low staffing, which were normal occurrences. On 08/25/25 at 11:24 AM, Activity Staff ZZ stated she only worked the weekdays, and direct care staff were expected to assist with scheduled activities on weekends. She also stated that the residents could complete self-guided activities from the activities cart if they chose to. On 08/25/25 at 12:30 PM, Administrative Nurse D stated she didn't feel the facility had issues with low weekend staffing. She stated the reports would often account for changes in both facility locations, and the reported times might be an error. The facility's "Staffing, Sufficient and Competent Nursing" policy, revised 04/2025, indicated the facility was to provide sufficient and competent staff to ensure the completion of care and services for all residents in accordance with resident care plans and the facility assessment.	F0725		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F0757		

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F0757 SS = D	Continued from page 20 §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: The facility had a census of 77 residents. The sample included 18 residents, with one reviewed for hydration. Based on observation, record review, and interview, the facility failed to hold blood pressure medication per the physician's ordered parameters for one resident, Resident (R) 47. This placed R47 at risk of low blood pressure and pulse side effects, and at risk of receiving unnecessary medication. Findings included: - The Electronic Medical Record (EMR) for R47 had diagnoses of pulmonary hypertension (high blood pressure in the arteries of the lungs), atrial fibrillation (rapid, irregular heartbeat), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and dementia with behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion). The" Quarterly Minimum Data Set" (MDS) dated 06/11/25, documented R47 had moderately impaired cognition. R47 required partial assistance with oral hygiene, toileting hygiene, upper body dressing, personal hygiene, mobility, transfers, and ambulation. The MDS documented R47 received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), and diuretic (a medication used to promote the formation and excretion of urine) medications daily.	F0757		

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F0757 SS = D	Continued from page 21 R47's "Care Plan" dated 06/24/25, initiated on 03/10/23, documented R47 received medications that had black box warnings (BBW - the highest safety-related warning that medications can have assigned by the Food and Drug Administration). The care plan further directed staff to administer medications as ordered, refer to the eMAR (electronic medication administration record), as medications that have a BBW were designated by a black box that would show the full warning. The care plan lacked further direction to staff regarding interventions related to antihypertension (a class of medication used to treat high blood pressure) medications. The care plan further failed to provide direction to staff for R47's Metoprolol (an antihypertensive) medication. The" Physician's Order," dated 12/06/24, directed staff to administer Metoprolol ER (extended release), 25 milligrams (mg), by mouth, in the morning, for atrial fibrillation and hypertension. Hold the medication if systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was less than 100 millimeters of mercury (mmHg), or heart rate (the number of times your heart beats in a minute) was less than 60 bpm (beats per minute). R47's "Medication Administration Record" (MAR) for July 2025 documented the following days R47 received Metoprolol when the heart rate was under the ordered parameters: 07/18/25 - 58 bpm 07/28/25 - 57 bpm 07/31/25 - 57 bpm R47's "MAR" for August 2025 documented the following days R47 received the Metoprolol when the heart rate was under the ordered parameters: 08/05/25 - 59 bpm 08/07/25 - 58 bpm 08/08/25 - 58 bpm 08/20/25 - 59 bpm On 08/25/25 at 08:00 AM, R47 sat in her wheelchair in the dining room waiting for breakfast.	F0757		

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F0757 SS = D	Continued from page 22 On 08/26/25 at 09:10 AM, Certified Medication Aide (CMA) R stated R47 had two different hypertension medications, and each had different physician parameters. CMA R further stated that she did not usually worry about the heart rate; she focused on whether R47's blood pressure was out of parameters. On 08/26/25 at 09:18 AM, Licensed Nurse (LN) G stated that staff are to follow the physician's orders and held the medication if the vital signs are out of the parameters. LN G further stated that the care plan should reflect that the hypertension medication R47 was prescribed could have side effects, and what staff should monitor for. LN G stated she would look at the care plan and update it with interventions for the hypertension medication. LN G stated she would provide education to the staff regarding the physician-ordered parameters. On 08/26/25 at 09:30 AM, Administrative Nurse F stated the medication should follow physician orders and notify the nurse if her heart rate was out of the physician-ordered parameters. Administrative Nurse F further stated that the care plan should reflect that the hypertension medication R47 was prescribed could have side effects, and what the staff should monitor for. The facility's "Medication Administration" policy, dated 08/19/20, documented medications were administered by licensed nurses or other staff who are designated to do so in this state. Medications were administered as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Staff were to obtain and record vital signs, when applicable or per physicians' orders, and hold medication for those vital signs outside of the physician's prescribed parameters.	F0757		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F0761		

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F0761 SS = E	Continued from page 23 §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: The facility had a census of 44 residents. Based on observation, interview, and record review, the facility failed to dispose of expired medications in a timely manner. This deficient practice placed residents at risk of receiving ineffective medication. Findings included: - On 08/18/25 at 08:20 AM, observation in the facility's East medication room revealed the following expired stock medications: One bottle of Docusate sodium (laxative medication) 500 micrograms (mcg), 100 tablets, with an expiration date of 11/27/24. One bottle of ASA (medication to reduce pain, fever, inflammation, and blood thinner) 325 milligrams (mg), 200 tablets, with an expiration date of 01/23/25. One bottle of Vitamin B12 (a vitamin the body uses to make and support healthy nerve cells) 500 mcg, 100 tablets, with an expiration date of 03/07/25. One bottle of Ibuprofen (anti-inflammatory medication) 200 mg, 100 tablets, with an expiration date of 06/05/25. On 08/18/25 at 08:25 AM, Licensed Nurse (LN) G verified that the expired drugs should have been disposed of. On 08/20/25 at 12:20 PM, Administrative Nurse D verified that the night shift should check the medication cart for expired medications. Each nurse	F0761		

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F0761 SS = E	Continued from page 24 administering the medications should check for expired medications and dispose of them if they have expired. The facility's "Medication Storage in the Facility" policy, dated 01/01/20, documented all medications in the premises would be stored in the medication carts or medication rooms according to the manufacturer's recommendation and sufficient to ensure proper sanitization, temperature, light, ventilation, moisture control, segregation, and security. The policy stated the medication rooms were routinely inspected by the facility designee for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications were destroyed in accordance with the facility's "Destruction of Unused Drugs Policy.	F0761		
F0812 SS = F	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: The facility had a census of 77 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to store, prepare, distribute, and serve food by professional standards for food service safety in one kitchen. This	F0812		

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F0812 SS = F	Continued from page 25 deficient practice placed the residents who received their meals from the facility's kitchens at risk for foodborne illness. Findings included: - On 08/24/25 at 09:21 AM, observation in the kitchen revealed a three-door refrigerator had the following: An unlabeled, undated ½ full 10-pound (lb.) package of pepperoni. An unlabeled, undated plastic bag with five hard-boiled eggs. An unlabeled, undated pan with 17 square chocolate chip cookies. An unlabeled, undated plastic bag of sliced ham. An unlabeled, undated plastic bag of square yellow cheese. An unlabeled, undated plastic bag with sliced onions. An unlabeled, undated plastic bag with shredded yellow cheese. An unlabeled, undated bowl of turkey salad. An unlabeled, undated bowl of apple cobbler cake. An unlabeled, undated bowl of lime Jello with apples. An unlabeled, undated plastic bag of chicken strips. An unlabeled, undated plastic bag of creamed corn. A chest-type freezer had an untied blue plastic bag with diced chicken and an unlabeled, undated plastic bag of whole kernel corn. The freezer had approximately ¾ inch of ice buildup all around the inside of the freezer. A two-door refrigerator had an unlabeled, undated plastic bag with six saltine crackers that had peanut butter in the middle. On 08/24/25 at 09:30 AM, Dietary Staff (DS) DD verified the above findings and stated staff had talked to the night cook about not labeling and dating food items. DS DD discarded the above items in the trash. On 08/25/25 at 11:00 AM, observation in the kitchen	F0812		

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F0812 SS = F	Continued from page 26 revealed the following: The wallpaper border, which ran behind the back of the oven and the three-sink area, had numerous places with peeling paper. A chest-type deep freeze that had approximately three-quarters-inch-thick ice buildup on the inside. A missing piece of linoleum, approximately two feet (ft) wide by two ft long by ¾ inch (in) deep, located underneath the dishwasher where the clean dishes came out. A missing piece of linoleum, approximately one ft wide by one ft long by ¾ in deep, located in the walking area when entering the dishwashing area A wall had approximately four feet long by six inches wide, located by a two-door refrigerator, with numerous different-sized areas with bubbling, peeling paint. A missing piece of linoleum, approximately four feet long by 18 inches wide, located in front of the three-sink area. An undated flour and sugar bin with numerous, different-sized blackish-gray specks around the outside of it. On 08/25/25 at 11:45 AM, DS BB verified the above findings and stated she was going to defrost the chest-type freezer this week. DS BB stated staff should label and date food items before placing them in the refrigerator or freezer. DS BB stated the facility had talked about replacing the linoleum. DS BB stated the wallpaper border had been peeling for a while, and the peeling paint by the two-door refrigerator was caused by a water leak. The “Kitchen Cleaning Schedule” had tasks listed for staff to complete daily, weekly, and monthly. The facility's "Cleaning and Sanitation of Dining and Food Service Areas Policy," revised 05/01/17, documented the director of food and nutrition services would determine all cleaning and sanitation tasks needed for the department.	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F0880		

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F0880 SS = D	Continued from page 27 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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	F0880		

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F0880 SS = D	Continued from page 28 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: The facility had a census of 77 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to ensure a sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections when staff failed to provide enhanced barrier precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) for Resident (R) 13. The facility staff failed to don (put on) gloves when emptying R13's urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag). The facility staff also failed to wear gloves when picking up an uncovered urinary catheter bag from the floor. This deficient practice placed the residents at risk for possible exposure to infection. Findings included: - On 08/24/25 at 09:30 AM, observation revealed no EBP signage outside R13's door, but personal protective equipment (PPE) was on the inside of R13's room door. On 08/24/25 at 02:50 PM, observation revealed R13's room door opened partway; he stood by a recliner with his uncovered urinary catheter bag and tubing on the floor in front of a recliner. Certified Nurse Aide (CNA) P entered the room without donning gloves or a gown and assisted R13 with sitting in a recliner. CNA P	F0880		

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F0880 SS = D	Continued from page 29 left the room with the catheter bag and tubing still on the floor. On 08/24/25 at 03:38 PM, observation revealed R13 sat in a recliner in his room with the door open, and his urinary catheter bag and tubing were on the floor. Licensed Nurse (LN) J entered the room, with an ungloved hand, picked up the catheter bag, placed it on a walker beside the recliner, and left the room. LN J stated she should have placed gloves on before picking up R13's urinary catheter bag. On 08/25/25 at 01:45 PM, observation revealed R13 sat in a recliner in his room with the door open. CNA O entered the room, without a gown, applied gloves, and asked R13 if she could empty his urinary catheter bag, and he replied, "Ok." CNA O retrieved a graduated cylinder from R13's bathroom, set it on the floor underneath the uncovered bag on a walker, unhooked the port from the bag, used an alcohol wipe on the port, opened the port, and drained yellow urine into the graduated cylinder. CNA O closed the port, used an alcohol wipe on the port, and placed it back into the holder on the urinary catheter bag. CNA O took the graduated cylinder into the bathroom, poured the urine into the toilet, set the graduated cylinder on top of the toilet, then removed and discarded the gloves and left R13's room. On 08/25/25 at 01:50 PM, when asked how staff could tell if a resident was on EBP, CNA O pointed to the green triangle in the upper corner of R13's entrance door frame and stated there was a green triangle in the corner of the entrance door. When asked if she should have placed a gown on before emptying R13's urinary catheter bag, she stated yes, but had forgotten. On 08/26/25 at 09:00 AM, Administrative Nurse F stated that staff are made aware of a resident being on EBP when they have a green triangle in the corner of the entrance door frame. EBP supplies are hung on the inside of the entrance door. Administrative Nurse F stated that staff could look at tasks on the computer, and the information is available in the care plan. Administrative Nurse F stated staff should keep a resident's urinary catheter bag and tubing off the floor, but if found uncovered on the floor, they should place gloves on to pick it up off the floor. The facility's "Catheter Care Policy, " revised 10/01/19, documented it was the policy of this facility to provide catheter care to all residents who have an indwelling catheter in an effort to reduce bladder and kidney infections.	F0880		

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F0880 SS = D	Continued from page 30 The facility's "Enhanced Barrier Precautions policy," revised 06/11/25, documented it was the policy of this facility to implement EBP precautions for the prevention of transmission of multidrug-resistant organisms (MDRO- common bacteria that have developed resistance to multiple types of antibiotics). Implementation of EBP would be performed with high-contact care activities. The policy documented high-contact resident care as follows: dressing, bathing, and transferring. Providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use with central lines (a long, thin tube inserted into a large vein in the neck, chest, or groin that reaches a major vein near the heart) urinary catheters, feeding tubes (tube for introducing high-calorie fluids into the stomach), tracheostomy(opening through the neck into the trachea through which an indwelling tube may be inserted), ventilator tube (a medical device that connects a person's windpipe to a ventilator machine, delivering air, oxygen, and medications directly into their lungs to help them breathe when they cannot do so effectively on their own), hemodialysis catheters (a procedure where impurities or wastes are removed from the blood), Peripherally Inserted Central Catheter (PICC) line (a long, thin tube inserted into a vein in the upper arm that is guided to a large central vein near the heart), midline (a long, thin, flexible tube inserted into a peripheral (outside, surface, or surrounding area of an organ, other structure, or field of vision) vein in the arm, typically for administering medications or fluids) catheters, and wound care: any skin opening requiring a dressing.	F0880		
F0883 SS = E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F0883		

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F0883 SS = E	Continued from page 31 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 77 residents. The sample included 18 residents, with five residents reviewed for immunizations, Resident (R) 3, R16, R34, R35, and R49, to include pneumococcal (a disease that refers to a range of illnesses that affect various parts of the	F0883		

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F0883 SS = E	Continued from page 32 body and are caused by infection) vaccinations. Based on record review and interviews, the facility failed to offer, obtain an informed declination, or a physician documented contraindication for the pneumococcal vaccination, including the PVC20 per the latest guidance from the Centers for Disease Control and Prevention (CDC). This placed the residents at risk for pneumococcal infection and related complications. Findings included: - Review of R3, R16, R34, R35, and R49 clinical medical records lacked evidence the facility or the resident representative received or signed a consent to receive or informed declination for the pneumococcal vaccine, including the PVC20. Review of R3's electronic health record revealed the resident was admitted to the facility on 03/08/18. R3 had not been offered or received a pneumococcal vaccine, including the PVC20, since admission. Review of R16's electronic health record revealed the resident was admitted to the facility on 08/16/24. R16 had not been offered or received a pneumococcal vaccine, including the PVC20, since admission. Review of R34's electronic health record revealed the resident was admitted to the facility on 12/01/23. R34 had not been offered or received a pneumococcal vaccine, including the PVC20, since admission. Review of R35's electronic health record revealed the resident was admitted to the facility on 02/08/17. R35 had not been offered or received a pneumococcal vaccine, including the PVC20, since admission. Review of R49's electronic health record revealed the resident was admitted to the facility on 09/21/19. R49 had not been offered or received a pneumococcal vaccine, including the PVC20, since admission. On 08/25/25 at 12:10 PM, Administrative Nurse D stated the resident's immunization status was assessed upon admission, and the website would be accessed through the Center for Medicaid and Medicare Services (CMS) to determine what immunizations the resident has received and when they received the vaccination. After they determine who would be eligible for the vaccinations, they would send an order over to the physician to be signed, and they would administer the vaccination at the facility. Administrative Nurse D verified the facility would provide the consent forms with the information regarding the vaccine to the resident	F0883		

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F0883 SS = E	Continued from page 33 and/or Durable Power of Attorney (DPOA) to sign. Administrative Nurse D verified that the director of Nursing was on medical leave and did not have a system in place to identify who needed what pneumonia vaccine. The facility's "Pneumococcal Vaccine" policy dated 01/31/22 documented the facility would offer the residents immunization against pneumococcal diseases in accordance with current CDC guidelines and recommendations. Each resident would be assessed for pneumococcal immunizations upon admission, and each resident would be offered a pneumococcal immunization unless medical contraindicated or the resident has already been immunized. Following assessment for any medically contraindicated conditions, the immunization may be administered in accordance with physician approval “standing orders.” The resident receiving the immunization, or the resident representative, would be provided with a copy of the CDC’s current vaccine information statement relative to the vaccine. The resident and/or representative retains the right to refuse the immunization, and a consent form shall be signed prior to the administration of the vaccine and filed in the resident’s medical record. The type of pneumococcal vaccine (PVC15, PVC20, or PPSV23/PPSV) offered would depend on the residents' age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations.	F0883		