STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E658	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHILLIPS COUNTY RETIREMENT CENTER	1300 STATE STREET , PHILLIPSBURG, Kansas, 67661

(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 investigation, K000271887.	F0000		
F0550 SS = D	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 from the facility.	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 = D	Continued from page 1 §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 identified a census of 29 residents. The sample included 12 residents, with one resident reviewed for dignity. Based on observation and interviews, the facility failed to ensure dependent Resident (R)20 was clothed appropriately when sitting in the TV area with her peers. Findings Included: - R20's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), pain, major depressive disorder (major mood disorder that causes persistent feelings of sadness), aphasia (condition with disordered or absent language function), and dementia (a progressive mental disorder characterized by failing memory and confusion). R20's "Quarterly Minimum Data Set" (MDS) dated 01/26/26 documented a Brief Interview of Mental Status (BIMS) score of zero which indicated severely impaired cognition. The MDS documented R20 was dependent on staff for all activities for daily living (ADLs). R20's "Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA)" lacked analysis. R20's "Care Plan" dated 03/19/22 documented R20 was at risk for impaired communication and directed staff to allow adequate time for R20 to respond and to provide clear instructions while doing care. On 03/09/26 at 10:37 AM R20 sat in her Broda (special wheelchair with the ability to tilt and recline) chair in the TV room. R20 wore a green hospital gown and had a white sheet over her lap. R20 was moving her hands in an up and down motion and raised her sheet and gown. R20's white incontinence brief was visible to the two male peers who sat in the TV room with her. On 03/11/26 at 10:04 AM, Certified Nurse's Aide (CNA) O stated R20 should be dressed or completely covered. She	F0550		

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F0550 SS = D	Continued from page 2 stated residents should not be exposed to other residents. On 03/11/26 at 09:54 AM, Licensed Nurses (LN) H stated residents should not be in the TV room wearing only a gown and sheet. She stated residents should be left in their rooms until the bath aide was ready for them. On 03/10/26 at 12:49 PM, Administrative Nurse D stated the facility protocol was for residents to be dressed and groomed before leaving their room. She stated she expected residents to be fully dressed when out in the TV area and said their incontinence brief should never be exposed. The facility's "Residents Rights Policy" undated documented each resident residing in this facility had the right and would be afforded the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility without interference, coercion, discrimination or reprisal. No staff member or contracted provider of care would hamper, compel, treat differently or retaliate against a resident for exercising Resident Rights. It was the responsibility of all who work in this facility, including employees of the facility and any others who provided services to the residents of the facility, to advocate and protect the rights of each resident. All staff members are trained in this Resident Right Policy at the time of employment, prior to providing care to residents, and at least annually to ensure full understanding and competency related to ensuring each resident's Resident Rights. Each resident would have the opportunity to exercise his/her rights as a citizen, or a resident of the United States and staff members will assist with exercise of those rights as needed by any/all residents.	F0550		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the	F0605		

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F0605 SS = D	Continued from page 3 resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §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- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or	F0605		

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F0605 SS = D	Continued from page 4 (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 29 residents. The	F0605		

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F0605 SS = D	Continued from page 5 sample included 12 residents, with five residents reviewed for unnecessary medication. Based on record review and interviews, the facility failed to ensure Resident (R)21's as-needed lorazepam (antianxiety medications that calm and relax people) cream had a 14-day stop date, or a specified duration with a physician's rationale for extended use. Findings included: - R21's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of hypertension (elevated blood pressure), and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), R21's "Quarterly Data Set" (MDS) dated 12/29/25 documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R21 needed substantial/maximal assistance for all activities of daily living except eating. The MDS documented R21 received an antidepressant (a class of medications used to treat mood disorder), hypnotic (a class of medications used to induce sleep), and an antianxiety medication during the observation period. R21's "Psychotropic Use Care Area Assessment" (CAA) dated 09/28/25 documented R21 had no adverse reactions noted related to her antidepressant treatment. R21's "Care Plan" documented: 03/05/25 R21 would be free from medication side effects. 03/05/25 Consult Pharmacist was to review R21's medication. 03/05/25 R21 would be free from symptoms and side effects related to Black Box Warning (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration). Education would be provided to durable power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to) and R21. R21's EMR under "Orders" documented the following physician's order: Lorazepam cream 0.5 milligrams (mg), apply every eight hours and as needed related to dementia. The order lacked a 14-day stop date or specified duration,	F0605		

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F0605 SS = D	Continued from page 6 R21's EMR lacked a physician's rationale for the extended use of as needed lorazepam. On 03/11/26 at 09:54 AM, License Nurse (LN)H stated the nurse taking the order should inform the physician the medication required a stop date. She stated the Director of Nursing was the second check for all orders. On 03/10/26 at 12:49 PM, Administrative Nurse D stated the facility's policy was to follow the regulations for as needed psychotropic medication. She stated all nurses taking orders would let the physician know as needed lorazepam required a stop date. The facility did not provide an unnecessary psychotropic drug policy as requested on 03/11/26.	F0605		
F0636 SS = E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems.	F0636		

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F0636 SS = E	Continued from page 7 (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 29 residents with 12 residents sampled. Based on interview and record review, the facility did not ensure completion of four residents comprehensive Minimum Data Set (MDS) assessments related to completion of the Care Area Assessments (CAA).	F0636		

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F0636 SS = E	Continued from page 8 Findings included: - R1's 09/28/25 "Annual MDS" triggered the following CAA areas, but were not completed: Activity of Daily Living (ADL) Functional / Rehabilitation Potential Urinary Incontinence and Indwelling Catheter Falls Nutritional Status Dehydration/Fluid Maintenance Dental Care Pressure Ulcer/Injury Psychotropic Drug Use R3's 10/07/25 "Annual MDS" triggered the following CAA areas, but were not completed: Cognitive Loss / Dementia Communication Urinary Incontinence and Indwelling Catheter Behavioral Symptoms Falls Pressure Ulcer/Injury Psychotropic Drug Use Pain R4's 08/25/25 "Annual MDS" triggered the following CAA areas, but were not completed: Activity of Daily Living (ADL) Functional / Rehabilitation Potential Urinary Incontinence and Indwelling Catheter Nutritional Status	F0636		

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F0636 SS = E	Continued from page 9 Pressure Ulcer/Injury Physical Restraints Pain R20's 04/16/25 "Annual MDS" triggered the following CAA areas, but were not completed: Cognitive Loss / Dementia Communication Urinary Incontinence and Indwelling Catheter Mood State Falls Nutritional Status Dental Care Pressure Ulcer/Injury Psychotropic Drug Use Pain On 03/10/26 at 04:06 PM, Administrative Nurse D acknowledged the above findings and stated the CAA should be filled out to more accurately trigger care plan interventions. Administrative Nurse D said she was still learning how to complete MDS assessments and missed the CAAs on the residents listed. Additionally, Administrative Nurse D stated she expected MDS assessments to accurately reflect each resident's status. The facility's undated "Minimum Data Set (MDS) Accuracy Audits" policy documented the facility was committed to ensuring the accuracy, timeliness and completeness of all MDS assessments.	F0636		
F0641 SS = E	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments.	F0641		

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F0641 SS = E	Continued from page 10 The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 29 residents, with 12 residents sampled. Based on interview and record review, the facility did not ensure accurate completion of five residents' Minimum Data Set (MDS) assessments related to the utilization of bedrails as restraints. Findings included: - R2's 01/20/25 "Quarterly MDS" documented bed rails were utilized as physical restraints daily during the look-back period. R4's 11/25/25 "Quarterly MDS" documented bed rails were utilized as physical restraints daily during the	F0641		

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F0641 SS = E	Continued from page 11 look-back period. R10's 01/16/26 "Quarterly MDS" documented bed rails were utilized as physical restraints daily during the look-back period. R11's 02/15/26 "Quarterly MDS" documented bed rails were utilized as physical restraints daily during the look-back period. R24's 12/20/25 "Quarterly MDS" documented bed rails were utilized as physical restraints daily during the look-back period. On 03/10/26 at 04:06 PM, Administrative Nurse D confirmed she had indicated bed rails as restraints on the MDS assessments of residents in the facility whose beds had bed rails installed on them, regardless of whether or not the resident used them. Administrative Nurse D confirmed the bed rails did not restrict the above-mentioned residents mobility and therefore did not meet the definition of a restraint. Administrative Nurse D stated she expected MDS assessments to accurately reflect each resident's status. The facility's undated "Minimum Data Set (MDS) Accuracy Audits" policy documented the facility was committed to ensuring the accuracy, timeliness and completeness of all MDS assessments.	F0641		
F0689 SS = G	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. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 29 residents with	F0689		

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F0689 SS = G	Continued from page 12 12 residents included in the sample and three residents reviewed for accident hazards. Based on observation, interview and record review, the facility failed to provide resident centered analysis after falls and interventions aimed to prevent falls for Resident (R)3, who had multiple falls with incomplete investigations of the causal factors and implementation of interventions to prevent further falls. Findings included: - R3's Electronic Health Record (EHR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and age-related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk). R3's 10/07/25 "Annual Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) could not be completed because the resident was rarely or never understood. Per staff assessment, R3 had memory problems and moderately impaired cognition. R3 had physical, verbal and other behavioral symptoms directed towards others that occurred one to three days during the look-back period. R3 rejected care and wandered one to three days during the look-back period. R3 had one non-injury fall and one fall with major injury since the last MDS. R3's 01/07/26 "Quarterly" MDS documented a BIMS interview could not be completed because the resident was rarely or never understood. Per staff interview, R3 had memory problems and moderately impaired cognition. R3 had physical, verbal and other behavioral symptoms directed towards others that occurred four to six days during the look-back period. R3 rejected care and wandered four to six days during the look-back period. R3 required partial/moderate assistance for sit-to-stand repositioning and transfers and substantial/maximal assistance for walking. R3 self-propelled in a wheelchair. The MDS documented R3 had two or more falls since the previous assessment. The 10/07/25 "Cognitive Loss / Dementia Care Area Assessment" (CAA) triggered for further development but was not completed. The 10/07/25 "Falls" CAA triggered for further development but was not completed. R3's "Care Plan" initiated on 05/16/24 and revised on	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E658	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2026

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F0689 SS = G	Continued from page 13 01/14/26, documented R3 was at risk for falls and noted the following interventions: Staff would anticipate and meet R3's needs. Staff would be sure R3's call light was within reach and encourage her to use it for assistance as needed. R3 required a prompt response to all requests for assistance. Staff would encourage R3 to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Staff would ensure R3 wore appropriate footwear when ambulating or mobilizing in a wheelchair. Staff would follow the facility fall protocol. Staff would initiate fall risk precautions such as ensure adequate lighting in the resident's room and bathroom at night, ensure the call light was within reach, ensure shoes were on during the day, and slipper socks were on the resident at night, ensure bed brakes were locked, minimize clutter in the room, keep floor surfaces dry during transfers and ambulation, and keep environment the same as much as possible. R3's "Care Plan" dated 08/09/24, documented R3 had an actual fall and noted staff would continue interventions, currently care planner for R3's at risk status. It further revealed the following interventions. Staff would provide assistance with two staff, a gait belt, and a four-wheeled walker (FWW), initiated on 10/25/24 and revised on 01/15/25. Staff would perform 15-minute visual checks, initiated 11/21/24 and revised on 01/15/25. Staff would ambulate R3 between 09:30 AM and 10:30 AM every day shift, initiated on 11/21/24. Staff would take R3 to the toilet right after evening meal, initiated on 12/12/24 Staff would place R3 in a recliner in front of the commons area, initiated on 01/27/25 Staff would place Dycem (a non-slip mat used for stabilization and gripping to prevent slipping) in R3's wheelchair, initiated 01/20/25.	F0689		

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F0689 SS = G	Continued from page 14 Staff were re-educated regarding agitated behaviors, initiated on 07/07/25 and revised on 01/26/25. Staff would place a green mattress on the floor against R3's bed, initiated on 08/11/25. Staff would replace R3's bed with a Hi-Low bed, initiated on 08/11/25 and revised on 01/26/26. Staff would walk away and ask a different staff member to assist R3 if she remained agitated after staff approached her, initiated and revised on 08/11/25. Staff were educated to be mindful of floor conditions when plumbers were working where R3 was, initiated on 09/24/25 and revised on 11/03/25. Staff would place grip strips on the floor on the side of the bed to assist the green mattress to stay where it should, initiated and revised on 01/15/26. Staff was re-educated on not leaving R3 alone when she was restless, initiated on 01/27/26. Staff would replace R3's mattress with a scoop mattress, initiated on 01/27/26. Staff were re-educated on the importance of checking on R3 according to her visual checks, initiated on 01/27/26 On 08/05/24 at 06:24 AM, a "Post Fall Evaluation" documented a noninjury fall at 06:45 AM. The facility's fall investigation report did not contain a root cause analysis (RCA) and Administrative Staff C documented on 08/05/24 an intervention for staff to place grip strips on the floor in front of both recliners. The facility was unable to provide fall investigations or interventions for falls dated 10/04/24, 11/01/24, and 12/23/24. The facility provided fall investigations for the following falls, however the facility investigations lacked casual factors of the falls and failed to implement interventions in a timely manner. The falls were dated as follows: 10/03/24 at 03:30 PM with an intervention on 10/25/24 for staff to assist R3 with the use of a gait belt and walker, initiated 22 days after the fall.	F0689		

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F0689 SS = G	Continued from page 15 11/02/24 at 10:52 PM with an intervention on 11/21/24 for staff to assist R3 to the toilet after the evening meal, initiated 19 days after the fall. 12/22/24 at 02:10 PM with an intervention on 01/09/25 to check R3 every 15 minutes, initiated 18 days after the fall. 12/22/24 at 01:45 PM with intervention on 01/09/25 to place R3 in a recliner in the commons area and provide a different wheelchair. 12/28/24 at 11:45 AM with an intervention on 01/09/25 to place R3 in a low bed. On 12/23/24 at 06:39 AM, a “Post Fall Evaluation” documented a noninjury fall at 06:40 AM. The facility did not provide a fall investigation. On 12/25/24 at 11:01 PM, a “Communication – with Physician” note documented R3 had increased pain to her pelvic area, right hip and lower back, and she walked with a mild limp. Staff documented there was no bruising or swelling to the pelvic area or shortening or rotation of either leg. R3’s EHR, under the scanned documents tab, revealed an order dated 12/26/24 from R3’s physician to obtain a pelvis and lumbar (lower back) spine x-rays. The document was signed off by an unknown staff member and Administrative Nurse D on 12/31/24. On 12/27/24 at 09:27 AM, a “Nurse’s Note” documented the facility received a fax response, and it was sent to radiology (x-ray). On 12/27/24 at 10:59 AM, a “Psychosocial Note” documented R3 was transported to the hospital for x-rays accompanied by family. R3’s EHR scanned documents dated 12/27/24 revealed radiology results for the pelvis x-ray exam performed on 12/27/24 at 11:16 AM, which documented a right greater trochanteric (hip) fracture. The document was signed by the radiologist on 12/24/24 at 11:30 PM. The document was signed by R3’s physician on 12/30/24. On 12/27/24 at 12:47 PM, a “Nurse’s Note” documented the facility received a telephone call from the hospital to inform them R3 needed to be sent to the Emergency Department (ED) due to a hip fracture. Staff informed R3’s representative and transported R3 back to the hospital. Staff documented the reports indicated	F0689		

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F0689 SS = G	Continued from page 16 surgical intervention was likely needed and R3 had family members in the facility who would accompany staff and R3 to the ED. On 12/27/24 at 11:05 PM, a “Nurse’s Note” documented R3 returned to the facility at 06:00 PM with instructions from the ED that the resident’s hip fracture did not require surgical intervention and included instructions for R3 to utilize a walker/wheelchair for locomotion, take Tylenol (acetaminophen) as needed (PRN) for pain, and instruction to follow up with her physician in 10 days. On 12/28/24 at 01:44 PM, an “Incident Note” documented R3 had an unwitnessed fall in her room at approximately 11:45 AM and was assessed to have shortening and subluxation (rotation) of the right leg. R3 was unable to keep her leg straight and was transported to the ED for evaluation. On 12/28/24 at 02:16 PM, R3’s EHR “Nurse’s Note” documented the facility called the ED for a status update for R3 and was informed R3’s fracture was worse, and the ED was working to transfer R3 to a different facility for additional treatment. On 12/28/24 at 05:17 PM, R3’s EHR “Nurse’s Note” documented the facility received a call from the ED and was notified R3 was transferred to a different hospital than originally planned because R3’s fracture was “complicated” and further fractured and dislocated. On 12/31/24 at 01:42 PM, R3’s EHR “Nurse’s Note” documented R3 returned to the facility from the hospital in the facility van with assistance from two staff in a wheelchair. R3 had a surgical dressing on her right hip/thigh and knee with orders to monitor her daily for signs of infection and to keep the dressing intact. On 01/03/25 at 12:23 AM, the facility’s fall report documented the resident had a fall with minor injury. The EHR progress notes did not contain an entry that documented the fall. The fall report did not contain a root cause analysis and Administrative Staff C documented on 01/09/25 an intervention was initiated to educate staff regarding the resident’s skin integrity and transfer protocols. On 02/12/25 at 07:23 PM, R3’s EHR “Nurse’s Note” documented the resident had a fall with major injury at 05:10 PM. R3 was assisted to her wheelchair and transported back to her room, where she was assessed for injury, had left leg pain, and was identified with	F0689		

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F0689 SS = G	Continued from page 17 outward rotation. Facility staff contacted Emergency Medical Services (EMS) for transport to the ED for evaluation. The facility's fall investigation did not contain a root cause analysis and Administrative Staff C documented a 02/13/25 intervention for staff to know R3 was sent to the hospital for surgery and then would be released to swing bed (a type of hospital setting that allows persons to transition from hospital treatment to recovery). The care plan team would assess R3 upon return to the facility for any applicable interventions. Review of the "Post Fall Evaluations" revealed R3 also had falls on 07/10/25, 09/23/25, 10/25/25, 12/05/25, 12/14/25 and 01/08/26. On 03/09/26 at 10:40 AM, R3 rested in a recliner in the common area with her eyes closed. On 03/09/26 at 02:00 PM, R3 sat in her wheelchair and self-propelled herself in the common area with peers and staff present. On 03/10/26 at 06:24 AM, R3 rested in her bed with her eyes closed. Her bed was in the lowest position with the mattress beside the bed on the floor. On 03/10/26 at 11:02 AM, R3 rested in a recliner in the common area with her eyes closed. On 03/10/26 at 09:48 AM, Certified Medication Aide (CMA) R stated after a fall was over and the resident was taken care of, fall interventions were added by Administrative Staff C and Administrative Nurse D. CMA R stated some interventions were communicated to staff on the Treatment Administration Record (TAR) such as the 15-minute visual checks, or the interventions would be passed on in shift report for a couple of days. CMA R said she did not have access to the care plan in the EHR and could only look in the EHR at the TAR. On 03/10/25 at 09:51 AM, Licensed Nurse (LN) G stated fall reports were routed to Administrative Staff C, and interventions to implement to prevent additional falls were created by Administrative Staff C and Administrative Nurse D. LN G stated the nurses working the floor did not create any interventions to prevent falls and did not have access to the resident's care plan. LN G stated there was an intervention book kept in the nurses' station for each resident and stated that staff did not know what the interventions for falls were until Administrative Nurse D and Administrative Staff C let the staff know, and then passed it on in shift change report.	F0689		

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F0689 SS = G	Continued from page 18 On 03/10/26 at 10:01 AM, Certified Nurse Aide (CNA) M stated staff did not have access to the care plan book most of the time since it was stored in Administrative Staff C's office. CNA M stated that after a fall, when staff filled out the paperwork, they documented what they thought an intervention could be, but the decision was ultimately up to Administrative Nurse D and Administrative Staff C. CNA M stated CNA staff do not have access to the care plan in the EHR. On 03/10/26 at 10:12 AM, Administrative Nurse D stated staff would have a meeting and develop an intervention (to prevent further falls) until the interdisciplinary team (IDT - a team of facility staff consisting of members of various departments including but not limited to; dietary, nursing, maintenance, therapy, etc.) could meet and develop an intervention to be placed on the care plan in the EHR. After a fall, the facility's IDT team which was composed of Administrative Staff C, Administrative Nurse D and Consultant GG would hold a meeting and develop a care plan intervention. Administrative Nurse D stated Administrative Staff C was responsible to update the care plan and communicate any changes to staff, who would then transmit the information via shift change report. Administrative Nurse D stated the care delivered by the staff was driven by the care plan and was unsure of the licensure/certification of Administrative Staff C and that this process was in place prior to her being hired by the facility. Administrative Nurse D stated that she was currently in school and was not able to regularly hold or attend IDT meetings to discuss falls in the facility. Administrative Nurse D stated prior to 08/2025 when she started school, IDT meetings were held once per week, but currently they were held whenever possible due to work/school scheduling conflicts. Administrative Nurse D stated that after a fall, the IDT team should meet within 24 to 48 hours to investigate the fall and develop care plan interventions and communicate that with staff. On 03/10/26 at 12:45 PM, Administrative Staff C stated she was a CNA and was in charge of the care plan interventions with Administrative Nurse D related to falls with consultation with Consultant GG. Administrative Staff C said she was in charge of the care plans and she would generate the focus, and Administrative Nurse D would input the interventions to generate the cares. Administrative Staff C said she and Administrative Nurse D would perform the root cause analysis of a fall investigation. Administrative staff attempted to have an IDT meeting every morning when	F0689		

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F0689 SS = G	Continued from page 19 Administrative Nurse D was in the building, but a resident could go two to four weeks between the fall and an intervention being developed and added to the care plan. Administrative Staff C stated floor nurses had the ability to add interventions to the care plan, but not the authority to perform this action. Administrative Staff C said that staff knew what interventions to implement after Administrative Staff C and Administrative Nurse D figured it out and it was communicated to all the staff via shift report. Administrative Staff C said she had the ability and authority to make care plan revisions without the knowledge or approval of the DON. Administrative Staff C said that after a fall, an intervention log was generated and a copy was placed in the red intervention book in the nurses' station and also placed in the falls tab on the care plan. This list was discussed with Consultant GG when she came to visit. Administrative Staff C said fall reports were routed to her and she assessed the situation to determine an appropriate intervention. On 03/10/26 at 01:51 PM, Administrative Nurse D recognized the fall investigations were incomplete and/or missing and did not contain a root cause analysis of why the fall occurred. Further, Administrative Nurse D identified the "notes" documented on the last page of each fall investigation were the intervention that was developed and should have been added to the care plan. Administrative Nurse D stated she expected fall investigations to be completed and written in such a manner that the reader would be able to visualize what happened without going to the area where the fall occurred. Administrative Nurse D stated floor nurses had the authority to create care plan interventions, however she was unsure if floor nurses had the authority to create interventions on the care plan. Additionally, Administrative Nurse D stated the facility did not have a fall packet to prompt staff on duty on what to document and where to document in the EHR to correctly and completely document a fall. The facility's undated "Admission Fall Prevention Protocol" policy documented that each resident in the facility would be provided services and care that ensured the environment remained as free from accident hazards as possible and that each resident received adequate supervision and assistive devices to prevent accidents.	F0689		
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): §483.35(b)(1)-(3)	F0727		

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F0727 SS = F	Continued from page 20 §483.35(b) Registered Nurse §483.35(b)(1)Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) 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: The facility reported a census of 29 residents. Based on observation, interview and record review, the facility failed to have Registered Nurse (RN) coverage for at least eight continuous hours daily as required. Additionally, the facility failed to employ a full-time RN to serve in the role of Director of Nurses (DON). Findings included: - Observation of the daily staffing posting sheet in the facility on 03/09/26 at 08:00 AM, 03/10/26 at 09:00 AM and 03/11/26 at 10:00 AM revealed no RN hours documented. Review of the Payroll Based Journal Staffing Data Report for fiscal year (FY) Quarter 4 2025 (July 1 to September 30) documented no RN hours on the following dates: 07/01 Tuesday (TU); 07/02 Wednesday (WE); 07/04 Friday (FR); 07/05 Saturday (SA); 07/06 Sunday (SU); 07/07 Monday (MO); 07/08 (TU); 07/09 (WE); 07/10 (TH); 07/11 (FR); 07/12 (SA); 07/13 (SU); 07/14 (MO); 07/15 (TU); 07/16 (WE); 07/17 (TH); 07/20 (SU); 07/21 (MO); 07/22 (TU); 07/23 (WE); 07/24 (TH); 07/25 (FR); 07/26 (SA); 07/27 (SU); 07/28 (MO); 07/29 (TU); 07/31 (TH) 08/01 (FR); 08/02 (SA); 08/03 (SU); 08/04 (MO); 08/05 (TU); 08/06 (WE); 08/07 (TH); 08/09 (SA); 08/10 (SU); 08/11 (MO); 08/14 (TH); 08/17 (SU); 08/18 (MO); 08/19 (TU); 08/20 (WE); 08/21 (TH); 08/22 (FR); 08/23 (SA); 08/24	F0727		

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F0727 SS = F	Continued from page 21 (SU); 08/25 (MO); 08/26 (TU); 08/27 (WE); 08/28 (TH); 08/29 (FR); 08/30 (SA); 08/31 (SU) 09/01 (MO); 09/02 (TU); 09/03 (WE); 09/04 (TH); 09/07 (SU); 09/08 (MO); 09/09 (TU); 09/10 (WE); 09/14 (SU); 09/15 (MO); 09/16 (TU); 09/17 (WE); 09/18 (TH); 09/21 (SU); 09/22 (MO); 09/23 (TU); 09/24 (WE); 09/25 (TH); 09/28 (SU); 09/29 (MO); 09/30 (TU) On 03/09/26 at 02:34 PM, Administrative Staff A stated the facility has not had an RN to serve in the roll of DON since 2023. Administrative Staff A stated the facility does not provide any skilled services since those services are provided by the hospital next door. Administrative Staff A confirmed the PBJ report to be accurate for dates with no RN coverage and declined to review the dates with the survey team. Administrative Staff A reported that the Licensed Nurse (LN) currently serving in the role of DON is a Licensed Practical Nurse (LPN) and is in a RN program with estimated completion date of 05/2026. Administrative Staff A stated the facility was actively recruiting RN staff but has been unsuccessful. On 03/11/26 at 12:07 PM, Administrative Staff A provided a document “Job Description – Director of Nursing” that did not specify the incumbent of the role of DON was required to hold an active and unincumbered license as an RN. The facility’s undated “Registered Nurse” policy documented the facility would employ the services of an RN for at least eight consecutive hours, seven days per week.	F0727		
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 §483.45(h)(1) In accordance with State and Federal	F0761		

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F0761 SS = E	Continued from page 22 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 reported a census of 29 residents, with one medication room, three medication carts, and one treatment cart. Based on observation, interview, and record review, the facility failed to ensure safe and secure medication storage for unauthorized staff and residents when licensed nursing staff left a medication cart unlocked and unsupervised. Findings included: - During an observation on 03/09/26, at 02:08 PM, Licensed Nurse (LN) H approached a medication cart parked directly outside of the nurse's station. She prepared medications in a small cup, locked her computer screen, and walked away from the medication cart that remained unlocked. LN H then walked down the hall into a resident's room, leaving the unlocked medication cart unattended by staff. The medication cart's lock remained outward, indicating the lock was not engaged, which left the cart accessible to anyone who attempted to access it. When the LN returned to the cart, she logged into her computer, prepared medications for another resident, locked her monitor screen and after closing the medication drawer she walked down the same hall into another resident's room and out of visual range. The medication cart remained unlocked and unsupervised during this time. When LN H returned to the medication cart, she logged back into her computer and noted her medication cart remained locked at this time. During an interview with LN H at 02:15 PM, on 03/09/26, she verified the medication cart and computer monitor should be locked every time it is left unattended.	F0761		

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F0761 SS = E	Continued from page 23 An interview with Administrative Nurse D on 03/11/26 at 12:46 PM revealed she expected staff to lock the medication cart before walking away. The “Medication Labeling and Storage” policy, dated 06/05/24, states all medications must be stored in a secure, locked location, accessible only to designated staff.	F0761		
F0838 SS = C	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and	F0838		

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F0838 SS = C	Continued from page 24 (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct	F0838		

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F0838 SS = C	Continued from page 25 care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 29 residents. The sample included 12 residents. Based on interviews and record review, the facility failed to conduct a thorough facility wide assessment to determine the resources necessary to care for residents competently during both day-to-day operations and emergencies. Findings included: - On 03/09/26 at 10:45 AM, Administrative Staff A provided an undated "Long-Term Care Self-Assessment".	F0838		

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F0838 SS = C	Continued from page 26 Review of the assessment revealed the following: The assessment failed to identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse's Aide (CNA) needed for each unit, patient acuity, and census. The assessment lacked staffing levels required for each shift to include evenings and weekends. The assessment failed to fully document the condition reports of the residents in the facility or document any potential extenuating circumstances that would make the condition report unusual. The assessment failed to document staff competencies and skill sets necessary to provide the level and types of care needed for specific resident populations. The assessment failed to fully document contractual agreements to outside providers for services available to residents in the facility for laboratory, radiology, therapy, hospital or transportation. Additionally, the facility failed to document contracts for lawn care and/or snow removal. On 03/11/26 at 09:11 AM, Administrative Staff A stated he reviewed the assessment annually and this was last performed on 10/23/25. Administrative Staff A reviewed the assessment and stated the facility does not have a vision or mission statement. He said he was unaware that the orange boxes on the assessment should be filled in per the assessment's instructions. Administrative Staff A stated staffing breakdown per unit should be completed and confirmed the assessment did not contain this information. Administrative Staff A confirmed the competencies that were unchecked indicated the listed staff were not responsible for the competency after he observed "Safety" and "Missing Resident" for "All Staff" were unchecked. Administrative Staff A stated he expected the facility assessment to be accurate. The facility's "Facility Assessment Policy" documented the assessment is the foundation to determine staffing levels and competencies and the facility would evaluate the resident population and identify the resources needed to provide the necessary care and services the residents require on an annual basis and any time significant changes are made to the care or service provided by the facility. The purpose included to	F0838		

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F0838 SS = C	Continued from page 27 consider specific staffing needs for each shift and adjust as necessary based on the resident population. The assessment would address the care required by the resident population as well as the staff competencies and skill sets necessary to provide the level and types of care required. The assessment would also address the facility's resources such as equipment, services provided, contracts and personnel (including education and/or training and competencies related to resident care). The assessment would include evaluations of any contracts or understandings that included third party agreements to provide goods, services and equipment to the facility during normal operations and emergencies.	F0838		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F0880		

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F0880 SS = E	Continued from page 28 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 29 residents. The facility identified two residents on Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record review, observations, and interviews, the facility failed to ensure Resident (R)1's continuous positive airway pressure (CPAP-ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask and R9, R7, and R6's nebulizer (a device that	F0880		

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F0880 SS = E	Continued from page 29 changes liquid medication into a mist easily inhaled into the lungs) masks were stored in a sanitary manner when not in use. The facility failed to ensure staff were wearing proper personal protective equipment (PPE) for EBP when doing direct care. The facility failed to transport dirty laundry using acceptable infection control practices. Findings included: - On 03/09/26 at 07:48 AM, during the initial walk-through of the facility, R1's CPAP mask laid directly on her bedside table. R1's CPAP mask was not stored in a sanitary container. R9's nebulizer mask laid on her bedside tablet. R9's nebulizer mask was not stored in a sanitary container. R7's nebulizer mask laid on her bedside table. R7's nebulizer mask was not stored in a sanitary container. R6's nebulizer mask hung over her side table and laid in her magazine rack. R6's nebulizer mask was not stored in a sanitary container. On 03/09/26 at 08:12 AM, Certified Nurses Aide (CNA) M carried unbagged dirty laundry from the bottom of Hall 2 holding the dirty clothing next to their uniform. CNA M was carrying the dirty laundry to a dirty laundry barrel in the middle Of Hall 2. On 03/10/26 at 07:36 AM, CNA 0 held a graduated cylinder (cylindrical vessel made of transparent plastic or glass, marked with precise, horizontal lines to measure liquid volumes), that contained dark amber colored urine. CNA 0 was wearing gloves only. CNA O was not wearing appropriate PPE for a resident with a urinary catheter. On 03/10/26 at 07:44 AM, CNA O stated she should have been wearing the proper PPE for EBP. CNA 0 stated all CNAs were trained on EBP. She stated there was a sign on the door to inform staff of the proper PPE to wear when taking care of residents with urinary catheters. On 03/11/26 at 09:55 AM, Licensed Nurse (LN) H stated all respiratory equipment should be rinsed and laid to dry, and the equipment should be covered while drying. LN H stated the equipment should be placed in a marked bag when not in use. She stated all staff were trained on proper PPE to wear when doing resident personal care for residents on EBP. She stated a gown and gloves should be worn when doing personal cares with a resident who had a urinary catheter.	F0880		

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F0880 SS = E	Continued from page 30 On 01/10/26 at 12:49 AM, Administrative Nurse D stated all respiratory equipment that was not in use should be placed in a bag labeled with the resident's name and date. She stated she expected staff to place respiratory equipment in a bag when the equipment was not in use. Administrative Nurse D stated all staff were trained on EHB precautions, each staff know when PPE was required when doing cares for residents. She stated staff should never carry dirty laundry next to their clothing; staff were to move the laundry tub next to the resident's door. The facility's "Respiratory Care" policy undated, documented the facility was committed to providing high-quality respiratory care to residents in accordance with evidence-based best practices, regulatory requirements, and physician orders. Nursing staff are responsible for ensuring proper assessment, intervention and monitoring of residents with respiratory conditions, whether acute or chronic. The purpose of this policy is to establish guidelines for the assessment, management, and monitoring of residents with any respiratory condition to ensure optimal respiratory function, prevent complications, and promote overall resident well-being. This policy applies to all nursing staff, respiratory therapists, physicians, and other healthcare professionals involved in the care of residents with respiratory conditions. The facility's "Laundry Protocols" policy undated, documented it was the policy of this facility to prevent the spread of infection by appropriate separation, collection, laundry and storage of laundry. Facility staff will handle, store, process, and transport linens in a method to prevent the spread of infection The facility was unable to provide a policy for EHB as requested on 03/11/26.	F0880		
F0881 SS = F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to	F0881		

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F0881 SS = F	Continued from page 31 monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 29 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to develop and implement the core elements of antibiotic stewardship to ensure an effective infection prevention and control program including antibiotic stewardship for the residents of the facility. Findings included: - Review of the "Infection Control Log" for tracking and trending infections from March 2025 through February 2026, lacked evidence of organism identification, duration of prescribed antibiotics, and the infections treated. The facility was unable to provide this upon request. On 03/10/26 at 10:39 AM, Administrative Nurse D confirmed she was also the facility's Infection Preventionist. She said she tracked who was taking an antibiotic in the Electronic Medical Record (EMR). She stated she was unable to provide tracking and trending for antibiotics. Administrative Nurse D stated the floor nurses would open the infection document for tracking, but the nurses would not fill out the form. She stated the only documents she had were the antibiotics the residents had taken for infections. The facility's “Infection Preventionist” policy undated, documented The Infection Preventionist is responsible for the effective direction, management and operation of the infection prevention program, including education of facility staff members and independent practitioners, and consulting with County and State Department of Health and Environment. The Infection Preventionist utilizes evidence-based practices such as those published by the Centers for Disease Control (CDC). Additionally, the Infection Preventionist ensures compliance with regulations and requirements from the Centers for Medicare and Medicaid Services (CMS) and other accrediting healthcare organizations and State regulatory agencies.	F0881		
F0882 SS = F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s)	F0882		

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F0882 SS = F	Continued from page 32 as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 29 residents. Based on record review and interviews, the facility failed to designate a staff member with the required qualification and certification as the Infection Preventionist, responsible for the facility's Infection Prevention and Control Program. Findings included: - During the entrance conference Administrative Staff A stated Administrative Nurse D was the Infection Preventionist for the facility. He stated she was a Licensed Nurse (LN) and had been continuing education for infection prevention. The facility provided documentation of continuing education topic for Enhanced Barrier Precautions (EHB) and how to implement a surveillance plan for antibiotic stewardship. On 03/10/26 at 10:36 AM, Administrative Nurse D stated she had been doing the Infection Preventionist duties for the facility. She stated she had been doing continuing education hours but did not have her certificate as an Infection Preventionist. Administrative Nurse D stated the facilities plan was for her to take the course and get her Infection Preventionist certificate. The facility's "Administration of Antibiotic" undated, documented antibiotics were essential treatments for serious infections and remain one of the most	F0882		

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F0882 SS = F	Continued from page 33 significant treatment options for control of microbials. The purpose of this policy is to provide guidance for staff on appropriate administration and follow-up of administration of antibiotics. Following the facility antibiotic stewardship policy, the facility and the practitioners ordering antibiotics would order antibiotic therapy only when indicated by laboratory testing and would be ordered for the shortest amount of time.	F0882		