STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175122	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Gardens Of Lenexa	**9701 MONROVIA STREET , LENEXA, Kansas, 66215**

(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 Recertification Survey and complaint survey regarding allegations in KS002703325, KS00269907, and KS002792091.	F0000		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §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 162 residents. The sample included 32 residents with one resident reviewed for accommodation of needs related to call lights. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 98 call light was within her reach. Findings Included: - R98's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), hypertension (elevated blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The "Quarterly Minimum Data Set" (MDS) dated 02/20/26 documented a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R98 was dependent on staff for all activities of daily living (ADLs). The "Falls Care Area Assessment" (CAA) dated 08/20/25 documented the fall CAA triggered related to R98 had one minor-injury fall during the lookback period. The	F0558		

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F0558 SS = D	Continued from page 1 CAA documented fall precautions were in place, and R98 was closely monitored. R98's "Care Plan" documented the following: 12/27/22 Keep R98's call light within her reach and answer promptly. 08/15/25 R98 had a minor injury witnessed fall, R98 was being wheeled in a wheelchair without foot pedals and put her feet down. R98 was to have foot pedals on wheelchair. 09/07/25 R98 had a fall with injury, intervention was R98 was not left alone in her wheelchair chair while awake. 05/19/26 R98 was at risk for falls due to a history of falls from poor safety awareness and impulsiveness. On 03/17/26 at 02:01 PM, R98 laid in her bed on her back with her eyes open and covered with her blankets. R98 was yelling out. R98's call light laid behind the headboard of her bed. R98's call light was not within her reach. On 03/17/26 at 02:05 PM, Certified Medication Aid (CMA) R stated residents should always have their call light within their reach. CMA R reached behind R98's bed and placed R98's pancake light on her abdomen. On 03/18/26, Licensed Nurse (LN)H at 08:14 AM stated residents should have their call lights next to them, or anywhere the resident could reach the call light. On 03/18/26 at 09:58 AM, Administrative Nurse D stated all residents should have their call lights where the call light was reachable by the resident. The facility's "Call Light Answering" policy dated 06/21 documented staff to go to the resident as soon as he/she calls. Staff were to answer call light within 15 minutes. Emergency lights should be responded to immediately to prevent injury. Check to see that the call light was within the resident's reach.	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	F0582		

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F0582 SS = D	Continued from page 2 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 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:	F0582		

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F0582 SS = D	Continued from page 3 The facility identified a census of 162 residents. The sample included three residents reviewed for beneficiary notifications. Based on interviews and record review, the facility failed to use the appropriate Advance Beneficiary Notice of Non-Coverage (ABN) Form CMS-10055 for resident (R) 194. Findings included: -The facility provided documentation noted R195's Medicare Part A last covered day was 10/31/25. The resident remained in the facility. Form CMS-20052 (11/2017) was provided instead of Form CMS-10055. During an interview with Administrative Staff A on 03/18/26 at 09:46 AM, she stated the correct ABN form was not provided for R195. During an interview on 03/18/26 at 09:52 AM with Social Services X stated ABN Form CMS-10055 was not provided to R195. The undated "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) Form CMS-10055 (2024)" policy was provided.	F0582		
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the	F0583		

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F0583 SS = D	Continued from page 4 facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 162 residents. The sample included 32 residents. Based on interview, observation and record review, the facility failed to protect the privacy of Resident (R) 10 and R96's personal and medical records. Findings included: - On 03/16/26 at 08:53 AM, observed an unattended medication cart in the 600 hallways. The computer screen was open with Personal Health Information (PHI) of R10's medication administration record displayed for four minutes. On 03/16/26 at 11:37 AM, observed a medication cart in 500 hallways unattended with PHI of R96, treatment orders displayed on the computer screen for over three minutes. On 03/16/26 at 08:57 AM, Certified Medication Aide (CMA) S reported that he should have closed the computer screen so no one could see R10's information. On 03/16/26 at 11:41 AM, Licensed Nurse (LN) L reported she should have closed the computer screen to maintain confidentiality of residents' medical information. On 03/17/26 at 01:38 PM, Administrative Nurse D expected that all resident information on the computer should be protected by closing the computer screen when the cart was unattended. The facility's undated "Residents' Rights" policy documented your right to privacy and confidentiality is	F0583		

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F0583 SS = D	Continued from page 5 as important to you as it is to any other person. You have the right of confidentiality for your personal and clinical records.	F0583		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 162 residents. The sample included 34 residents, with two reviewed for abuse. Based on observation, record review, and interview, the facility staff failed to identify a resident to resident altercation as potential abuse and report to the facility's Administrator as required. Findings included: - R62's Electronic Health Record (EHR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) with behaviors, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory	F0609		

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F0609 SS = D	Continued from page 6 failure,) major depressive disorder (major mood disorder that causes persistent feelings of sadness) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear.) R62's "Quarterly Minimum Data Set" (MDS), dated 02/19/26, recorded R62 had severely impaired cognitive function. The MDS recorded R62 required extensive assistance with transfers, activities of daily living (ADL), and propelled in a wheelchair. The MDS documented the residents receiving Hospice services. The MDS documented that the resident had no behavior and received antianxiety (a class of medications that calm and relax people), antidepressants (a class of medications used to treat mood disorders), and hypnotics (a class of medications used to induce sleep). R62's "Activities of Daily Living (ADL) Care Plan," dated 02/26/26, recorded R62 required staff assistance with most ADL care. R62's "Care Plan" documented she used her legs and feet to maneuver her wheelchair. R62's "Behaviors Care Plan," dated 02/26/26, recorded she had behaviors that were disruptive to herself and others, and she would become combative and resist cares. The care plan documented R62 could be physically aggressive with other residents and staff. R62's care plan directed staff to attempt non pharmacological interventions before staff administered as needed medications to calm her, assess for pain, unmet needs, toileting needs, hunger, offer a snack, activity of interest, quite time, leave the resident for 5-10 minutes, offer a back rub, hug, hold her hand, or obtain a dip stick urinalysis if indicated. The care plan directed staff to administer medication as ordered and review her behavior at least quarterly and as needed by the care plan team. The "Nurses Notes" dated 09/04/25 at 02:26 PM documented R62 was involved in a resident-to-resident altercation. R62 was observed grabbing another resident's arm and covering her mouth. The Nurses Notes documented R62 required redirection and physical moving of hands. R62 was removed from the area and placed at the window with 1 on 1 interaction with the nurse to calm down. The note documented that staff would continue to monitor for safety due to the residents' poor safety awareness.	F0609		

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F0609 SS = D	Continued from page 7 The facility lacked an investigation related to the event and was unable to provide evidence the incident was reported to the SA. On 03/17/26 at 08:25 AM, hospice aide pushed R62 from her room to the dining room in a wheelchair, dressed in street clothes. Staff served R62 her breakfast and she was able to eat independently. On 03/17/26 at 02:45 PM, Administrative Staff B stated the nurse's notes on 09/04/25 at 02:26 PM documented R62 was in an altercation with R134. After an interview with the nurse involved Administrative Staff B stated the nurse was a "new nurse," and it was her first day on the job, and she documented what the trainer nurse told her however, it was not documented correctly. Administrative Staff B verified the nurse told her after interview on 03/17/26, it should have been documented R62 grabbed R134's sweater, and she was unsure what the nurse meant when she documented the resident covered her mouth. Administrative Staff B stated they were going to have the nurse put in an additional progress note stating R134's arm was not grabbed, and documented R62 grabbed R134's sweater. Administrative Staff B verified they did not have a witness statement from the nurse who wrote the note, but they would obtain one today. Administrative Nurse B verified they would have the nurse put in a note today, a late entry describing the incident that was described to the administrative staff when the nurse was interviewed today. Administrative Staff B verified it was the facility policy to have staff report an incident of this nature immediately and the facility would investigate and determine what further action would need to be taken. On 03/18/26 at 08:05 AM, Administrative Nurse D stated the nurse who documented the entry was a "brand new nurse" and had a staff nurse who trained her that day, and the new nurse apparently did not document the incident correctly so the staff nurse did not feel it was abuse and felt she did not have to report the incident to administration. Administrative Nurse D verified an incident of abuse should be reported immediately to the administration and they would investigate, gather witness statements and report to the State agency as indicated.	F0609		

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F0609 SS = D	Continued from page 8 The facility's "Abuse, Neglect, and Exploitation" policy, dated September 2022, documented the facility maintains a work and living environment that is professional, and residents are free from threat or occurrence of harassment, abuse to include verbal, physical, mental or sexual, neglect corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardian, friends, or other individuals. The policy documented to report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including the State Survey Agency, within five working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken. The policy documented each individual shall report allegations or suspicions of abuse, neglect, or exploitation to the Administrator or supervisor. The Administrator, or designee, shall report to the State agency and one or more law enforcement entities for the political subdivision in which the facility is located, and reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. Each individual shall report immediately, but not later than two hours after forming the suspicion, if the events that caused the suspicion result in serious bodily injury, or not, later than 24 hours if the events that caused the suspicion do not result in serious bodily injury. The policy documented the Administrator or designee on duty would assess the resident, including the size and location of any injury, and assure proper documentation of the date, time, and location of the reported or suspected incident. An incident report would be completed, and the physician and family would be notified as soon as possible. The Administrator or Director of Nursing is responsible for notifying the Regional Nursing Supervisor to report alleged violations of the resident safety policy to ensure prompt investigation and corrective actions are in place. The Administrator or designee would interview the residents as well as any nursing, housekeeping, laundry, dietary, social service staff, any visitors, volunteers or others who may have knowledge of the occurrence or who may have been in the vicinity at the time of the incident. The Administrator or designee on duty would prepare a written summary of each interview.	F0609		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation	F0610		

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F0610 SS = D	Continued from page 9 CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 162 residents. The sample included 34 residents, with two reviewed for abuse. Based on observation, record review, and interview, the facility failed to identify a resident to resident altercation as potential abuse and initiate an investigation. Findings included: - R62's Electronic Health Record (EHR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) with behaviors, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure,) major depressive disorder (major mood disorder that causes persistent feelings of sadness) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear.) R62's "Quarterly Minimum Data Set" (MDS), dated 02/19/26, recorded R62 had severely impaired cognitive function. The MDS recorded R62 required extensive assistance with transfers, activities of daily living (ADL), and propelled in a wheelchair. The MDS documented the residents receiving Hospice services. The MDS documented that the resident had no behavior and received antianxiety (a class of medications that	F0610		

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F0610 SS = D	Continued from page 10 calm and relax people), antidepressants (a class of medications used to treat mood disorders), and hypnotic (a class of medications used to induce sleep). R62's "Activities of Daily Living (ADL) Care Plan," dated 02/26/26, recorded R62 required staff assistance with most ADL care. R62's "Care Plan" documented R62 used her legs and feet to maneuver her wheelchair. R62's "Behaviors Care Plan," dated 02/26/26, recorded R62 had behaviors that were disruptive to herself and others, and she would become combative and resist cares. The care plan documented R62 could be physically aggressive with other residents and staff. R62's care plan directed staff to attempt non pharmacological interventions before staff administered as needed medications to calm her, assess for pain, unmet needs, toileting needs, hunger, offer a snack, activity of interest, quite time, leave the resident for 5-10 minutes, offer a back rub, hug, hold her hand, or obtain a dip stick urinalysis if indicated. The care plan directed staff to administer medication as ordered and review her behavior at least quarterly and as needed by the care plan team. The "Nurses Notes" dated 09/04/25 at 02:26 PM documented R62 was involved in a resident-to-resident altercation. R62 was observed grabbing another resident's arm and covering her mouth. Th Nurses Notes documented R62 required redirection and physical moving of hands. R62 was removed from the area and placed at the window with 1 on 1 interaction with the nurse to calm down. The note documented that staff would continue to monitor for safety due to the residents' poor safety awareness. The facility was unable to provide evidence a thorough investigation was conducted related to the resident to resident altercation. On 03/17/26 at 08:25 AM, hospice aide pushed R62 from her room to the dining room in a wheelchair, dressed in street clothes. Staff served R62 her breakfast and she was able to eat independently. On 03/17/26 at 02:45 PM, Administrative Staff B stated the nurse's notes on 09/04/25 at 02:26 PM documented	F0610		

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F0610 SS = D	Continued from page 11 R62 was in an altercation with R134 after interview with the nurse involved stated the nurse was a “new nurse,” and it was her first day on the job and she documented what the Trainer nurse told her however, it was not documented correctly. Administrative Staff B verified the nurse told her after interview on 03/17/26 it should have been documented R62 grabbed R134’s sweater, and she was unsure what the nurse meant when she documented the resident covered her mouth. Administrative Staff B stated they were going to have the nurse put in an additional progress note stating R134’s arm was not grabbed, and documented R62 grabbed R134’s sweater. Administrative Staff B verified they did not have a witness statement from the nurse who wrote the note, but they would obtain one today. Administrative Nurse B verified they would have the nurse put in a note today, late entry describing the incident that was described to the administrative staff when the nurse was interviewed today. Administrative Staff B verified it was the facility policy to have staff report an incident of this nature immediately and the facility would investigate and determine what further action would need to be taken. On 03/18/26 at 08:05 AM, Administrative Nurse D stated the nurse that documented the entry was a “brand new nurse” and had a staff nurse that trained her that day, and the new nurse apparently did not document the incident correctly and so the staff nurse did not feel it was abuse and felt she did not have to report the incident to administration. Administrative Nurse D verified an incident of abuse should be reported immediately to the administration and they would investigate, gather witness statements and report to the State agency as indicated. The facility's "Abuse, Neglect, and Exploitation" policy, dated September 2022, documented the facility maintains a work and living environment that is professional, and residents are free from threat or occurrence of harassment, abuse to include verbal, physical, mental or sexual, neglect corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident’s symptoms. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardian, friends or other individuals. The policy documented to report the results of all investigations to the administrator or his or her designated representative and to other officials in	F0610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175122	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0610 SS = D	Continued from page 12 accordance with State law, including the State Survey Agency, within five working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken. The policy documented each individual shall report allegations or suspicions of abuse, neglect, or exploitation to the Administrator or supervisor. The Administrator, or designee, shall report to the State agency and one or more law enforcement entities for the political subdivision in which the facility is located, and reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. Each individual shall report immediately, but not later than two hours after forming the suspicion, if the events that caused the suspicion result in serious bodily injury, or not, later than 24 hours if the events that caused the suspicion do not result in serious bodily injury. The policy documented the Administrator or designee on duty would assess the resident, including the size and location of any injury, and assure proper documentation of the date, time, and location of the reported or suspected incident. An incident report would be completed, and the physician and family would be notified as soon as possible. The Administrator or Director of Nursing is responsible for notifying the Regional Nursing Supervisor to report alleged violations of the resident safety policy to ensure prompt investigation and corrective actions are in place. The Administrator or designee would interview the residents as well as any nursing, housekeeping, laundry, dietary, social service staff, any visitors, volunteers, or others who may have knowledge of the occurrence or who may have been in the vicinity at the time of the incident. The Administrator or designee on duty would prepare a written summary of each interview.	F0610		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and	F0693		

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F0693 SS = D	Continued from page 13 §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 162 residents; the sample included 32 residents with one resident reviewed for tube feeding (administration of nutritionally balanced liquefied foods or nutrients through a tube). Based on observation, interviews, and record review, the facility failed to ensure Resident (R) 47s head of bed was elevated as his enteral feed formula was administered through R47's gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) by a feeding pump. Additionally, the facility failed to administer R47's enteral feed by the physician's order. Findings included: - R47's Electronic Medical Record (EMR) documented diagnoses which included diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and dysphagia (swallowing difficulty). R47's "Significant Change Minimum Data Set" (MDS) dated 02/04/26, documented a Brief Interview for Mental Status (BIMS) score of four, which indicated severely impaired cognition. R47's MDS documented he required total assistance with all activities of daily living. R47's "Nutritional Status Care Area Assessment" (CAA) dated 02/20/26, documented that R47 had a significant change had occurred and R47 had elected to receive hospice services. The CAA triggered due to R47's body mass index (BMI is a measure of body fat based on height and weight that applies to adult men and women), which was below the recommended range for his age and gender. R47 received a pureed diet due to his dysphagia. R47's "Care Plan" dated 03/11/26 revealed staff instructed to keep the head of bed elevated to prevent aspiration (inhaling liquid or food into the lungs). R47's "Care Plan" dated 03/11/26 revealed staff	F0693		

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F0693 SS = D	Continued from page 14 instructed to look in treatment administration record for current feedings and flush orders, as these would change frequently. R47's "Physician Orders" dated 03/09/26 revealed enteral feeding, elevate the head of bed 30 degrees continuously. R47's "Physician Orders" dated 03/16/26 revealed enteral feeding formula Glucerna 1.5 flow rate 50 milliliters (ml) per hour every shift. R47's "Physician Orders" dated 03/16/26 revealed stop tube feeding for two hours daily for gut rest from 04:30 AM to 06:30 am once a day. R47's "Physician History and Physical Note" dated 03/11/26 revealed R47 was admitted to the hospital with urinary tract infection, acute kidney injury, and hyponatremia. R47 was treated for all the above problems in Additionally, placement of a G-tube with the tube feeding. R47's "Readmission Nutrition Assessment" dated 03/16/2026 at 12:39 PM revealed R47 was readmitted to the community on hospice and had peg placement. Recommended product change to Glucerna 1.5 in an effort to promote weight gain as well as provide gut rest for two hours per day. Recommended to keep rate of Glucerna 1.5 at 50ml/hour for 22 hours per day (off from 4:30 am-6:30 am), which may also allow R47 to be hungry for breakfast. Continue with 150ml water flush q 4hrs. On 03/16/2026 at 11:51 AM, observation of R47 laid in his bed that was flat. R47 had an enteral feeding running via a feeding pump at 50ml/hour. The enteral feeding bag was labeled 03/16/26 at 04:00 AM, 50ml/hour and 150 ml/hour of water every four hours. The label lacked what type of enteral feed was in the bag. On 03/17/2026 07:35 AM, observed R47 was in his bed, eyes closed. The head of bed was elevated to 30 degrees. The enteral feeding pump was not on, and the enteral feeding tubing was not connected to R47's G-tube. The enteral feeding bag was labeled dated 03/17/26 at 03:30 AM, Glucerna 1.5 rate of 50ml/hr, and 150 ml of water every four hours. On 03/17/2026 at 08:19 AM, observed R47 was awake in bed he laid on his back with head of bed elevated at 3 degrees, the tube feeding remained off and not connected to R47.	F0693		

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F0693 SS = D	Continued from page 15 On 03/17/26 at 09:45 AM observed Licensed Nurse (LN) I turned R47's feeding pump on after she completed medications. LN I connected R47's G-tube to the enteral feeding line. When the feeding pump was turned on the screen displayed R47 had 48 ml of enteral feed infused and 39 ml of water infused after the feeding was changed at 03:30 AM 03/17/26. LN I positioned R47 on his left side in bed, lowered his bed and R47's head of bed remained elevated at 30 degrees. On 03/17/2026 at 10:34 AM, observed R47 laid on his right side in bed, his eyes were closed, and the head of his bed was elevated at 10 degrees. R47's enteral feeding was on and running at 50 ml/hour. On 03/16/2026 at 12:09 PM, LN J entered R47's room and Certified Nurse Aide (CNA) MM was in R47's room washing his hands. CNA MM reported he had not provided care for R47 he reported he was just in the room to wash his hands and walked out. LN J did not notice that R47's bed was flat until she was asked if R47's enteral feeding was running. LN J reported that R47's head of bed should be elevated and was unsure of how high the head of bed should be elevated, as she asked how it should be. LN J then elevated R47's head of bed to 30 degrees and reported she would let R47's nurse be aware. On 03/16/26 at 12:15 PM, CNA P reported that he had taken care of R47 around 11:00 AM today and thought he had elevated the head of bed to 30 degrees and then reported that CNA MM was also assigned to R47's hallway, so maybe he did it. On 03/17/2026 at 10:36 AM, CNA M reported she had repositioned R47 a few minutes ago. CNA M reported R47's head of bed should be elevated to 180 degrees. CNA M reported she thought she raised R47's head of bed. CNA M reported R47 would not be able to lower the head of bed as the controller was not in reach. On 03/17/26 at 12:58 PM, LN I reported R47s tube feeding had not been turned back on until 09:45 AM after medication administered. LN I reported the night nurse reported to her during AM report that R47's feeding tube was shut off late this morning. LN I reported she was unsure what time the tube feeding was shut off as she did not write that information down on her report sheet. LN I reported she believed that the night nurse told her at 05:00 AM. LN I reviewed R47's enteral feeding orders and reported could not locate an order for the tube feeding to be stopped at 04:30 AM for two hours and start the tube feeding at 06:30 AM.	F0693		

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F0693 SS = D	Continued from page 16 LN I reviewed the Consultant Staff GG Registered Dietician's documented note in EMR from 03/16/25. LN I reported she would not receive the Consultant Staff GG recommendations. LN I reported that R47s head of bed should be always elevated at least 30 to 45 degrees. On 03/17/26 at 01:10 PM, Consultant Staff GG reported that she made the recommendation on 03/16/26 to shut off the R47's enteral feed for two hours in the morning and she delivered the recommendations to interdisciplinary team members on 03/16/26. Consultant Staff GG reported that Administrative Nurse F or Certified Medication Aide (CMA) E who completed medical records would receive the orders from the provider and place the order in the EMR. Consultant Staff GG reviewed R47's orders in EMR and confirmed R47 had the order placed 03/16/26 to shut off the enteral feeding for two hours from 04:30 AM to 06:30 AM every day. Consultant Staff GG reported she expected the LNs to follow the providers' orders. On 03/17/2026 at 01:38 PM, Administrative Nurse D reported that she expected the staff to keep R47's head of bed always elevated when the tube feeding was running. Administrative Nurse D reported she expected the LNs to follow the physician orders for his enteral feed. The facility's policy "Gastrostomy Tube Care" dated 06/2021 lacked documentation of the head of bed elevated for enteral feedings. The facility's policy "Physician Orders, Following" dated 06/2021 documented it was the policy of the community to ensure that all Licensed Professional Nurses (RN/LPN /LVN) and other Healthcare Professionals follow Physician Orders in accordance with State, Federal regulations, and their respective practice acts.	F0693		
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 17 §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 identified a census of 132 residents. The sample included 32 residents, with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 9s as needed diphenhydramine (an antihistamine used to treat allergy symptoms, hay fever, the common cold, insomnia, and motion sickness) medication order had a diagnosis or reason to administer medication. Findings included: - The Electronic Medical Record (EMR) for R9 documented a diagnosis of insomnia (inability to sleep) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R9's “Annual Minimum Data Set (MDS)” dated 01/11/26 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R9’s MDS revealed she had no skin issues, and she was independent with her activities of daily living. R9's " Psychotropic Drug Use Care Area Assessment" (CAA) documented that R9 triggered CAA due to being prescribed psychotropic medications for anxiety that may increase the risk of adverse consequences. R9 would be closely monitored. R9’s “Care Plan,” 03/16/26, lacked documentation for diphenhydramine.	F0757		

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F0757 SS = D	Continued from page 18 R9's 11/12/25 "Physician Orders" documented diphenhydramine, give 50 milligrams (mg), by mouth three times a day as needed. The order lacked a reason/diagnosis. R9's EMR reviewed from 11/12/25 through 03/17/26; the EMR lacked documentation of the diphenhydramine order in progress notes, provider notes, dermatology notes, pharmacy notes, and psych notes. On 03/16/26 at 11:30 AM, R9 was up in her room putting her sandals on. R9 reported she does not know all of her medications. On 03/17/2026 at 07:43 AM, R9 was in her bed with her eyes closed. On 03/18/2026 at 08:45 AM, R9 ambulated independently with a walker at the front of the facility. She reported she was going out with activities. She reported that if she needed any medication, she would let the nurse know, and reported she had a lot to choose from. On 03/17/26 at 04:05 PM, Consultant Staff GG Pharmacist reviewed R9's EMR and reported that R9 did not have a reason or diagnosis for her as needed diphenhydramine order. Consultant Staff GG reported she missed that on her last medication review. Consultant Staff GG reported all medications are required to have a diagnosis code and or reason. On 03/18/26 at 07:42 AM, Certified Medication Aide (CMA) S reported all as needed medications need to have a reason to give the medications. CMA S reported the nurse instructed the CMAs when to administer an as needed medication to a resident. On 03/18/26 at 07:58 AM, Licensed Nurse (LN) K reported that all medications required a diagnosis or a reason why a medication was ordered. On 03/18/2026 at 12:18 PM, Administrative Nurse D reported that R9's diphenhydramine order since 11/12/25 should have had a reason why the medication was needed. Administrative Nurse D reported that all medications required a diagnosis and reason. The facility did not provide a policy on as needed medications orders.	F0757		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)	F0759		

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F0759 SS = D	Continued from page 19 §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 162 residents. Twenty-six medication administrations were observed. Based on observation, interview and record review the facility failed to ensure a medication error rate of less than five percent when five errors were identified, resulting in a medication error rate of 19.23 percent. Finding included: - R47's "Physician Orders" recorded an order for ferrous sulfate tablet (an iron supplement), administer 325 milligrams (mg) tablet by gastric tube (G-tube: tube surgically placed through an artificial opening into the stomach), once a day for anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), date ordered 03/10/26 R47's "Physician Orders" recorded an order for sennosides-docusate (used to prevent occasional constipation). Administer 1 tablet: 8.6-50 mg by gastric tube, twice a day, the order lacked a diagnosis, date ordered 03/10/26. R47's "Physician Orders" recorded an order for tamsulosin capsule (used to relieve symptoms such as difficulty urinating, weak stream, and urgency). Administer 1 capsule 0.4 mg crushed by gastric tube, once a day for malignant neoplasm (the tendency of a medical condition, especially tumors, to become progressively worse, most familiar as a characteristic of cancer) of the bladder, date ordered 03/10/26. During an observation on 03/17/26 at 09:01 AM, Licensed Nurse (LN) I prepared R47's medications and reported that she was not going to administer the tamsulosin capsule as the order documented daily and the medications administration record documented daily, however, the tamsulosin medication card dated 03/02/26 documented to be administered at bedtime. LN I reported she would need to clarify the order before she	F0759		

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F0759 SS = D	Continued from page 20 administered the tamsulosin. During an observation on 03/17/26 at 09:12 AM, LN I crushed R47's ferrous sulfate 325 mg tablet and sennosides-docusate 8.6-50 mg and administered the medications via R47's gastric tube. - R134's "Physician Orders" recorded an order for docusate sodium (used to prevent occasional constipation) 100 milligrams (mg) capsule, administer 2 capsules by mouth, one time a day for constipation, date ordered 06/12/25. R134's "Physician Orders" recorded an order for trazodone (an antidepressant, a class of medications used to treat mood disorders), 50 mg tablet, administered 1 tablet twice a day for a psychotic disorder (any major mental disorder characterized by a gross impairment in reality perception), date ordered 10/25/25. An observation on 03/17/26 at 11:15 AM, LN G crushed R134's trazodone 50 mg tablet, and 2 docusate sodium 100 mg capsules, and administered the medications by mouth to R134 mixed in pudding. On 03/17/26 at 12:58 PM, LN I reported that she had not administered the tamsulosin at that time and reported she had to contact the provider for clarification. LN I reported that the pharmacy would be delivering the correctly labeled tamsulosin card soon for R47. LN I reported she was unsure if the ferrous sulfate tablet and the senna plus tab could not be crushed and reported there was no direction on the order to not crush the medications. On 03/17/26 at 01:38 PM, Administrative Nurse D reported that R47's medications were going to be changed to a different form as the ferrous sulfate and sennosides-docusate should not have been crushed. On 03/17/26 at 04:05 PM, Consultant Staff HH Pharmacist revealed completed a medication review on 03/10/26 when R47 was readmitted and followed the orders from the hospital. She reported she had not requested a change of medication form for the sennosides-docusate and ferrous sulfate tablets. Consultant Staff HH reported the sennosides-docusate and ferrous sulfate tablets should not have been crushed when administered. On 03/18/26 at 08:00 AM, Administrative Nurse D reported that R134's docusate sodium and trazodone tablets should not have been crushed.	F0759		

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F0759 SS = D	Continued from page 21 The facility's policy "Medication Administration" dated January 2021 documented do not crush medications when it was contraindicated on a caution label or in the Physicians' Desk Reference (PDR, now known as the Prescribers' Digital Reference, is a primary, authoritative resource for Food and Drug Administration -approved drug information, including dosage, side effects, and interactions).	F0759		
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 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 162 residents, with 32 residents sampled. Based on observation, interview, and record review, the facility failed to ensure three of six medication carts observed were locked while unattended. This deficiency had the potential to affect 19 residents located on the 500 hallways and 29 residents located on the 600 hallways. Findings included:	F0761		

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F0761 SS = E	Continued from page 22 - On 03/16/2026 at 08:16 AM, an observation of an unlocked and unattended medication cart was in the 600 hallways for three minutes unattended; Licensed Nurse (LN) CC walked by and locked the medication cart and walked away. On 03/16/2026 at 08:53 AM, an observation of an unlocked unattended medication cart in the 600 hallways. At 08:55 AM, Certified Medication Aide (CMA) S returned to the unlocked medication cart checked on the computer and walked away from the unlocked medication cart and into a resident's room. CMA S returned to the unlocked medication cart two minutes later to prepare medications. On 03/16/26 at 11:37 AM, an observation of an unlocked and unattended medication cart in the 500 hallways for three minutes. LN L was in R96's room, the medication cart drawer was opened without LN L noticing. On 03/16/26 at 08:20 AM, LN CC 08:20 AM reported that the nurse medication cart stored the residents' insulins and treatment supplies, and LN CC reported the cart should always be locked when not in use or in eyesight. On 03/17/26 at 08:57 AM, CMA S reported the medication cart should always be locked when not in use. On 03/16/26 at 11:40 AM, LN L exited R96's room and reported that she should have locked the medication cart. On 03/17/26 at 01:38 PM, Administrative Nurse D reported that she expected the staff to always lock all the medication carts when not in use and unattended. The facility's policy "Medication Administration" dated January 2021 documented keeping the cart in visible range or locking all items prior to going into the resident's room.	F0761		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F0880		

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F0880 SS = D	Continued from page 23 §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 transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F0880		

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F0880 SS = D	Continued from page 24 §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 reported a census of 162 residents. The sample included 32 residents. Based on interviews, observation and record review, the facility failed to utilize 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) when providing direct care to a Resident (R) 3 with a coccyx (distal tip of the spine/tail-bone) wound and while providing direct care to R 120 and R 101 with open and scabbed wounds. Additionally, the facility failed to ensure adequate hand hygiene before and after personal care for R 3, and while passing ice between residents. Furthermore, the facility failed to sanitize the mechanical lift between residents' use and maintain R6's catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) tubing laid directly on the floor. Findings included: - On 03/16/26 at 09:40. Certified Nurse Aide (CNA) H brought a sit-to-stand/mechanical lift from one room directly to room 507 without sanitizing the lift prior to using the mechanical lift to transfer R6, with an indwelling catheter. On 03/17/2026 at 09:48 AM, observed R6 sat on the edge of his bed with his clothes off, his indwelling urine collection drainage bag laid directly on the floor. CNA P entered R6's room, sanitized their hands and applied gloves. CNA O and CNA P failed to apply a gown when providing direct care to R 6 with Enhanced Barrier Precautions (EBP) as required with a resident with an	F0880		

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F0880 SS = D	Continued from page 25 indwelling catheter to prevent the spread of infection and cross contamination. CNA O and CNA P assisted R6 to the restroom with the unsantized sit to stand lift. R6's catheter bag was placed under the wheelchair (w/c) by CNAs O and P upon his transfer from the bed to the W/C. The resident's urine drainage collection bag and tubing dragging directly on the floor when the resident rolled to the restroom. CNA O and CNA P transferred the resident to the toilet with the unsanitized sit to stand lift. CNA P removed his gloves and failed to sanitize his hands before exiting R 6's room. On 03/16/26 at 09:51 AM, CNA stated he should have worn a gown while providing direct high contact care to a resident with EBP. He confirmed the signage on the resident's door indicated the resident with EBP and indicated Personal Protective Equipment (PPE), including gloves, gowns, and hand sanitizing due to his catheter. On 03/16/26 at 09:54 AM, CNA O should have worn a gown, gloves, and sanitized their hands. Before applying gloves and after removal of gloves. Both CNAs state they "usually" wipe down the sit to stand mechanical lift, but they were in a hurry to get residents up for breakfast. On 03/17/2026 at 07:48 AM, CNA M passed ice out to the residents in hallway 500. He left the ice scoop in the ice cooler and failed to close the lid to the cooler, which he left unattended when he entered the resident's rooms. On 03/17/2026 at 07:50 AM, CNA M closed the lid While the another CNA N went to two resident's rooms down the hallway and brought two drinking cups out and filled the cups and let the ice scoop in the cooler and the lid open while leaving the left the scoop in the ice left the lid open and took two cups back to the resident's room and returned to the ice cooler any proceeded down the hall retrieved two more cups from the resident room and returned to the ice cooler and filled drinking cups and return them to the residents room. She came out quickly and without sanitizing her hands throughout the ice water pass in 500 halls.	F0880		

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F0880 SS = D	Continued from page 26 On 03/17/2026 at 07:52 AM, CNA M closed the ice cooler again and reported that the scoop should not be left in the ice as there is a holder, and the ice cooler should remain closed. 03/17/2026 7:53 AM, CNA N reported on inquiry, she normally closes the lid and keeps the scoop out of the ice and in the holder, and confirmed she did not wash her hands in-between residents' cups as she should to prevent cross contamination and the spread of infection. On 3/17/2026 at 09:10 AM, Licensed Nurse (LN) I reported that the ice coolers should be closed when not is use and the ice scoop should not be left in the ice cooler but placed in the holder. LN I reported that the staff should wash their hands in between residents. 03/17/2026 at 10:22 AM, Resident 3 was lying on his bed. Observed door signage on his door indicating the resident required EBP, which included PPE of gowns, gloves, and hand hygiene when providing direct care to the resident. The PPE setup was present for staff accessibility to the required PPE. Upon inquiry, the resident stated he did not know why he was on EBP and did not know what that meant. He did not have an indwelling device such as a catheter, no obvious signs of wound concerns, or what that meant. He was well groomed, raised his arms on verbal cues, and stated sometimes he itches under his elbow; no redness or skin integrity issues noted. On 03/17/2026 at 10:25 AM, CNA Q entered R 3's room, sanitized and put on gloves and gown. He provided incontinence care to the resident and placed the sling for the mechanical lift under the resident. CNA Q removed his gloves and gown after positioning the sling, removed his gloves, and sanitized his hands between dirty and clean during incontinence care and positioning the sling. He left the room and stated he needed help to transfer the resident. On 03/17/2026 at 10:33 AM, CNA, MM returned to resident's room accompanied by CNA Q to help with mechanical lift transfer. Neither CNAs applied gowns during transfer for resident's transfers. On 03/17/2026 at 10:43 AM, CNA Q verified resident	F0880		

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F0880 SS = D	Continued from page 27 required EBP, which included PPE of gowns when giving direct care. Stated understanding of EHBP was to wear a gown when providing direct care, such as incontinent care, but since he provided incontinent care earlier, he wore a gown, but he was not sure why, and that EBP precautions were initiated due to that. On 03/17/26 at 01:34 PM, Administrative Nurse E reported she expected the staff to wear the PPE for residents that have EBP, have indwelling catheter urine collection bags always covered and off the floor. Staff should wash their hands when they remove their gloves before applying new gloves. On 03/18/2026 at 08:38 AM, Administrative Nurse E reported that she expected the staff to close the ice cooler when not in use, and she expected the staff to place the scoop in holder and perform hand hygiene between residents and only do one cup at a time. 03/16/2026 3:30 PM, observed R120 with blood spots over his white T-shirt on arms and open areas on skin on bilateral arms and legs. Resident with rash red raised over the body, the areas on his arms and legs with some scabbing present. The resident was scratching his arms and legs, blood was noted on his leg coverings no bandages were present. Visible open areas on his legs, some wounds with scabs. On inquiry, he said the areas itch, but he does not like the cream they put all over him, he would just like something on the open areas and something for the itching. R201 reported the areas were an issue for a couple of months. Additionally, he raised his white T-shirt to reveal a red raised rash covering his chest and torso and across his shoulders. The residents' door lacked signage for EBP to include specific PPE use due to wounds, set up for PPE was not present for staff accessibility. On 03/17/2026 at 11:18 AM, R120 was in bed, with bright red blood noted on his pillowcases and bedding. His socks were crumpled below his mid leg with red staining throughout. Open areas were pronounced on his arms and legs. Review of the resident's electronic medical record "Skin Condition Report" lacked a detailed assessment of the resident's skin, open areas, and rash as follows:	F0880		

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F0880 SS = D	Continued from page 28 On 03/17/2026 at 12:16 PM, LN MM, Administrative Nurse E, and LN J conducted a skin assessment for R120, revealing the resident with 13 wounds which included: Left upper arm 0.5centimeters (cm) x 0.8 cm by Unable to determine (UTD)due 100% scabbed Left forearm 0.6 cm by 0.5 cm by 0.1 cm, open area, no scabbing present, red wound bed with blood present Left lateral arm 0.3 cm by 0.3 cm by 0.1 cm, no scabbing present, red wound bed with blood present Left Wrist 0.1cm by 0.5 cm by 0.1cm, open area with bright red wound bed, blood present Left medial wrist 1.0 cm by 0.5 cm by 1 red wound bed with blood present, 100% scabbed Left wrist superior 0.5 cm by 0.7 cm by 0.1UTD scabbed raised area left hand 0.5 cm by 0.5cm by UTD due to fully scabbed On 03/17/2026 at 12:16 PM, LN MM, Administrative Nurse E, and LN J confirmed the above findings, stated the open wounds had bled on the president's personal clothing and linen. He used his w/c to move around his room, and he refused personal care on occasion. Staff changed his linen and clothing, which were blood stained. The housekeeping staff clean his room. Open wounds should indicate the resident should have enhanced barrier precautions to include signage, PPE set up and use of gloves, gowns and hand hygiene when giving care. Staff verified EBP had not been implemented for this resident. Additionally, dressing should be applied to open areas with bleeding to prevent cross contamination and the potential for the spread of infection. The facility policy titled "Infection Prevention and Control Surveillance," dated 02/25/26, documented all skin lesions must be covered, and dressing must be dry. The facility will require staff to perform hand hygiene when necessary. The facility will provide infection prevention and control training regarding hand hygiene, standard precautions, proper cleaning and disinfecting of equipment, and other infection prevention and control topics as determined by program needs.	F0880		