

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175229		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/29/2026	
NAME OF PROVIDER OR SUPPLIER PARKWAY OPERATOR LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 749 BLAKE STREET , EDWARDSVILLE, Kansas, 66111			
(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			F0000			
F0812 SS = F	The following citations represent the findings of a Health Recertification Survey and complaint investigation 3117613 and 3110058. The census was 38. The sample included 12 residents. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain a sanitary kitchen to prepare food for the residents who received meals from the kitchen. Findings included: - On 07/28/2026 at 11:52 AM, during observation of the kitchen, three Hydrion PH sanitizer paper testing			F0812			

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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F0812 SS = F	Continued from page 1 strips, stored above the three-compartment sink, were found outdated, with two that had expiration dates of 09/30/2018 and one with an expiration date of 07/15/2025. On 07/27/2026 at 11:52 AM, Dietary Staff BB stated he was unaware the testing strips had an expiration date. Upon request, the facility failed to provide a policy on kitchen sanitation.	F0812					
F0887 SS = E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was	F0887					

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F0887 SS = E	Continued from page 2 provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to follow the latest guidelines from the Centers for Disease Control and Prevention (CDC) to administer the COVID-19 vaccine following written consent or obtain informed declination documentation for Resident (R) 2, R1, R8, and R23. Findings included: 1. R2's Electronic Medical Record (EMR) documented a declination for the COVID-19 booster vaccine on 06/14/2024, but lacked a current declination for the latest COVID-19 booster. 2. R1's EMR documented a COVID booster received on 06/14/2023. The facility had a consent for a COVID-19 booster vaccine to be administered but lacked a signature date or record that R1 had received the most current vaccine. 3. R8 EMR documented a consent for a COVID-19 booster dated 07/20/2026 but lacked documentation that R8 had been administered the current COVID-19 booster vaccine. 4. R23 documented the declination of a COVID-19 booster on 12/18/2024. The facility failed to document a current COVID-19 booster vaccine offer.	F0887					

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F0887 SS = E	Continued from page 3 On 07/29/2026 at 11:29 AM, Administrative Nurse D verified the lack of documentation related to the COVID-19 vaccine. Administrative Nurse D reported the facility utilizes the month of October to update the immunization status for the residents. The facility works with the local health department for the administration of vaccines. Administrative Nurse D verified the residents should receive information and the most current vaccination recommendations from the CDC. The facility's "Vaccination of Residents, including influenza, Pneumococcal, RSV and COVID-19" dated 09/2025 documented the community will offer the COVID-19 vaccination when available to the community. The vaccine may be offered and provided directly by the community or through a third-party arrangement with a pharmacy partner, local health department, or other appropriate health entity. The residents or their representatives will receive education on the benefits and risks of receiving the COVID-19 vaccine. Document refusals in the medical record.	F0887					
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy	F0628					

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F0628 SS = D	Continued from page 4 of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.			F0628			

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F0628 SS = D	Continued from page 5 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written	F0628					

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F0628 SS = D	Continued from page 6 notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent	F0628					

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F0628 SS = D	Continued from page 7 of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to complete a recapitulation (a concise summary of the resident's stay and course of treatment in the facility) for Resident (R) 48, upon the resident's discharge from the facility. Findings included: - R48's Electronic Medical Record (EMR) documented diagnoses of dementia without behavioral disturbances (a progressive mental disorder characterized by failing memory and confusion), heart failure, and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type two. The "Admission Minimum Data Set" (MDS), dated 05/11/2026, documented R48 had moderately impaired cognition. R48 required supervision with toileting hygiene, showers, transfers, and set-up assistance with personal hygiene. R48 had lower functional impairment on both sides, did not ambulate, and wanted to be discharged back to the community. R48's 05/20/2026 "Care Plan" documented the following interventions for R48: 05/21/2026- Talk to his family member to make sure she was on board with him living with her. The care plan directed staff to work with the KCVA (Kansas City Veterans Administration) to obtain assistance with transferring R48 to the Veterans Administration (VA) in Illinois and to address the financial issues associated with moving out of state. The care plan further directed staff to educate R48 on good self-care behavior, and Social Services (SS) would provide visits to assist R48 with the adjustment and to help with discharge planning. The "Nurse's Note," dated 06/02/2026 at 08:53 AM, documented R48 went to Social Services X and stated he was discharging home with his family today. R48 stated his family member was in Kansas City and planned to pick him up. The note further documented that nursing staff were notified and would get their discharge paperwork ready.			F0628			

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F0628 SS = D	Continued from page 8 The "Nurse's Note," dated 06/02/2026 at 10:01 AM, documented R48 was discharged from the facility to home and picked up by family; the Nurse Practitioner (NP) was notified and ordered to have R48 discharged from the facility. R48's EMR lacked a recapitulation of his stay in the facility. On 07/28/2026 at 11:09 AM, Administrative Nurse D verified there was no recapitulation for R48's stay. Administrative Nurse D stated that normally the discharge paperwork was started at admission, but R48 was originally supposed to be long-term; one day he came and stated his ride was coming and he was going home. The facility's "Discharge Summary and Plan" policy, dated 03/2026, documented that when a resident's discharge was anticipated, a discharge summary and post-discharge plan would be developed to assist the resident to adjust to his/her new living environment, that was safe and able to provide the care they required post-transfer. The discharge summary would include a recapitulation of the resident's stay at the facility, and a final summary of the resident's status at the time of the discharge and as permitted by the resident.		F0628				
F0761 SS = D	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		F0761				

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F0761 SS = D	Continued from page 9 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to adequately store drugs and biologicals for Resident (R) 35, R15, and R38 when staff failed to date insulin upon opening. Findings included: - On 07/27/2026 at 08:40 AM, during the initial tour of the facility, Licensed Nurse (LN) H was preparing medications. Upon inspection of the medication cart, R35's Novolog (short-acting insulin) pen, R15's Glargine (long-acting insulin) pen, and the R38 Novolog vial lacked an open date. LN H verified the facility's policy was to date insulin when opened for use, and insulin should have been dated with the open date. On 07/29/2026 at 11:54 AM, Administrative Nurse D verified that the insulin should be dated when opened and put into use. The facility's "Storage of Medications" policy, dated 10/2024, documented that the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed, per state regulation.	F0761					
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.	F0849					

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F0849 SS = D	Continued from page 10 §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing			F0849			

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F0849 SS = D	Continued from page 11 needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and	F0849					

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F0849 SS = D	Continued from page 12 coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.			F0849			

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F0849 SS = D	Continued from page 13 This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure coordinated care and services provided by the facility with the care and services provided by hospice for one resident, Resident (R) 4. Findings included: - R4's Electronic Medical Record (EMR) documented diagnoses cerebral infarction (stroke-sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), tracheostomy (opening through the neck into the trachea which an indwelling tube may be inserted), and dysphagia (swallowing difficulty). R4's "Quarterly Minimum Data Set" (MDS), dated 06/18/026, documented that R4's cognition was not assessed. R4 was dependent upon staff for all activities of daily living (ADL). The MDS documented the resident received tracheostomy care, had a gastrostomy tube (G-tube: a tube surgically placed through an artificial opening into the stomach, and received hospice services. R4's 06/02/2026 "Care Plan" documented the following interventions for R4: 09/09/2025- The care plan directed staff to administer medication as ordered, monitor for verbal and nonverbal cues of pain, and intervene accordingly. The care plan directed staff to notify Hospice of any changes in condition and had a DNR (do not resuscitate). The care plan lacked the frequency and type of support visits, supplies, and medical equipment provided by hospice. Review of R4's clinical record revealed the resident was admitted to hospice care on 09/06/2025. The facility had a plan of care provided by hospice in a communication book dated 06/04/2026. On 08/27/2026 at 08:30 AM, R4 was in bed with his eyes closed. On 07/29/2026 at 1:18 AM, Administrative Nurse F stated she was new to the position and had training on the care plan process. Administrative Nurse F further stated she would update the care plan with the information required related to his Hospice care.			F0849			

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F0849 SS = D	Continued from page 14 On 07/29/2026 at 12:10 PM, Administrative Nurse D stated the care plan should reflect the care provided by both the staff and Hospice. The facility's "Hospice Program" policy, dated 12/2025, documented the community may contract for hospice services for residents who wish to participate in such programs, including services that would be provided and the coordination of services. To promote continuity of care, collaborate with the hospice, nursing home, and resident/representative on a coordinated care plan noted in the medical record to include, but not limited to, resident choices regarding care, all services needed, interventions based on assessments, and the provider responsible for performing specific services.	F0849					
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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;	F0880					

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F0880 SS = D	Continued from page 15 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high-contact care) for Resident (R) 5 and R35's wound care and R4's gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) and tracheostomy care (opening through the neck into the trachea through	F0880					

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F0880 SS = D	Continued from page 16 which an indwelling tube may be inserted). Findings included: - On 07/29/2026 at 10:33 AM, Licensed Nurse (LN) I provided wound care for R5's buttock pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). LN I donned gloves, removed the soiled dressing, then proceeded to clean the wound and apply ordered treatment and dressing to the wound. LN I failed to utilize a gown barrier, which was available at the resident's door, during any part of the procedure. On 07/29/2026 at 11:00 AM, LB I provided wound care for R35's ulcer to the plantar (bottom) area of the right foot. LN I donned gloves to remove the dressing. LN I then donned a barrier gown to complete the treatment and dressing. LN I stated that she had forgotten to place a barrier gown on to provide wound care, due to being nervous during the observation of the care for wounds on both R5 and R35. On 07/29/2026 at 11:33 AM, Administrative Nurse D verified that staff should have donned a gown and gloves during the treatment of wounds. The facility's "Multidrug-Resistant Organisms (MDRO) and Enhanced Barrier Precautions (EBP) policy, dated 05/2026, documented that EBP expanded the use of PPE and referred to the use of gowns and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact activities. Nursing Home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. - On 07/28/2026 at 08:15 AM, R4's room door had an 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) sign and a door caddy with gowns and gloves in it. Licensed Nurse (LN) G went into R4's room to administer morning medications via R4's gastrostomy tube (G-tube: a tube surgically placed through an artificial opening in the stomach) and to perform tracheostomy (opening through the neck into the trachea, through which an indwelling tube			F0880			

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F0880 SS = D	Continued from page 17 may be inserted) care. LN G washed his hands and donned clean gloves and used a 60-milliliter (mL) syringe to check for residual (the amount of fluid remaining in the stomach before a feeding or at regular intervals) before administering his medications. LN G removed his soiled gloves, washed his hands, and donned a new pair of gloves. LN G flushed his G-tube with 60 mL of water, administered the medications, and flushed his G-tube with another 60 mL of water. Further observation revealed LN G removed his soiled gloves, washed his hands, donned clean gloves, and prepared R4 for tracheostomy care. LN G removed the 4 x 4 gauze pad (medical dressings used to clean, cover, and absorb drainage from wounds) from under the tracheostomy tube. LN G changed his gloves and stated his right hand was his sterile hand, and then he cleansed the area with a mixture of sterile saline and hydrogen peroxide. LN G removed the inner cannula (a removable tube that slides inside the main tracheostomy tube) and put in a new one. LN G changed his gloves, removed the tracheostomy tie (a securement strap that holds a tracheostomy tube firmly in place against the neck), and replaced it with a clean one. LN G then took R4's oxygen saturation (percentage of oxygen in the blood). On 07/28/2026 at 08:40 AM, LN G stated both the residents in the room were on EBP precautions and staff were supposed to wear a gown and gloves while providing care to R4. On 07/29/2026 at 12:18 PM, Administrative Nurse D stated staff are to wear a gown and gloves with cares for any resident on EBP. The facility's "Multidrug-Resistant Organisms (MDRO) and Enhanced Barrier Precautions (EBP)" policy, dated 05/2026, documented enhanced barrier precautions are used during high -contact resident care activities. For residents with indwelling medical devices such as feeding tubes and tracheostomies, staff are to wear personal protective equipment (PPE- gowns, face shields and/or eyeglasses/goggles, and gloves).			F0880			
F0851 SS = C	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit			F0851			

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F0851 SS = C	Continued from page 18 to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS.			F0851			

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F0851 SS = C	Continued from page 19 §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to submit complete and accurate staffing information through the Payroll-Based Journal (PBJ- an electronic record mandated by the Centers for Medicare and Medicaid Services (CMS) that details direct care staffing hours worked in long-term care settings) as required, resulting in a trigger for excessively low weekend staffing. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2026 Quarter (Q) 1 and Q2 indicated excessively low weekend staffing. Review of the facility's Nursing staffing schedules for the above quarters revealed adequate staffing on duty was provided. On 07/29/2026 at 12:15 PM, Administrative Nurse D stated Administrator A submitted the nursing information for the PBJ report and stated they were always staffed well on the weekends, as they do have agency staff assisting when needed. The facility's "Payroll Based Journal" policy, dated 10/2025, documented the community would submit payroll data in a uniform format to CMS, including staffing information for community, agency, and contract staff. The facility distinguished employees from agency and contract staff and reported information about direct care staff, and they specified whether the individual is an employee of the facility or is engaged by the facility under contract or through an agency.			F0851			