STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045477	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monette Manor, LLC	669 Hwy 139 North Monette, AR 72447

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on observation and interview, the facility failed to ensure the Infection Preventionist had completed specialized training in infection prevention and control before taking the position. The failed practice had the potential to affect all 79 residents residing in the facility. The findings include: Review of the facilities Infection Prevention and Control Program (IPCP) states the facility must designate one or more individuals who are responsible for the facility IPCP who have the specialized training in infection prevention and control. During an interview on 04/22/2026 at 12:39 PM the Director of Nurses (DON) indicated she had not completed specialized training beyond her initial professional training as a nurse, nor received a completion certificate for infection prevention and control. The DON stated I have not completed a full module of the necessary training as of yet for the Infection Preventionist.

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 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interviews and record review, the facility failed to maintain an infection prevention and control program that included an Antibiotic Stewardship Program (ASP)) this failed practice had the potential to affect all residents who resided in the facility. The findings include: Review of an undated facility Antibiotic Stewardship Manual revealed that the Infection Preventionist (IP) will track antibiotic use and monitor adherence to evidence-based criteria and compile reports related to monitoring antibiotic usage and resistance data. Review of a facility Antibiotic Stewardship Tracking and Trending document revealed no documentation for the months of March and April of 2026. Last documentation for tracking/trending was February. Documentation in February showed antibiotic use, with a resident's name, s/s were documented, but the tracking/trending of the different halls for the month of February were not completed. During an interview on 04/22/2026 at 12:36 PM, the Director of Nursing indicated they were responsible for the Antibiotic Stewardship Tracking and Trending as the Infection Preventionist but I have not completed the training for the Infection Preventionist, I have not even completed one module. At the current time there was no Infection Preventionist in the building. During a second interview on 04/23/2026 at 11:56 AM, the Director of Nursing indicated that that the Antibiotic Stewardship Tracking and Trending was important to determine where and when infections arise, the days and who was working. The previous DON was the Infection Preventionist and kept up with the Antibiotic Stewardship. When she left, I was literally handed the job as the Infection Preventionist, so it hasn't been kept up to date.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, interviews, record review, and facility policy review, it was determined that the facility failed to develop and implement a Comprehensive Person-Centered Care Plan for one (Resident #36) of five residents reviewed that included measurable objectives and timeframes to meet a resident's medical, nursing, needs that were identified in the Comprehensive Assessment Specifically, Resident #36's Care Plan did not address or focus on an active diagnosis of type 2 diabetes, nor include interventions to guide staff in monitoring for complications. The findings include: Review of an admission Record revealed the facility admitted Resident #36 on 12/29/2025 with diagnoses that included type 2 diabetes with elevated blood sugars, congestive heart failure, chronic kidney disease, Alzheimer's, high blood pressure, cognitive communication deficits, depression, insomnia and anxiety. Review of Resident #36's admission Minimum Data Set (MDS), with an Assessment Reference Date of 01/05/2026, revealed Resident #36 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact and was independent for daily decision making. The MDS indicated Resident #36 used a wheelchair for ambulation with no impairments to arms or legs. Active diagnosis listed included coronary artery disease, heart failure, hypertension, kidney failure, and diabetes mellitus. The MDS indicated insulin injections were administered seven out of the seven days assessed for the look back period. Resident #36's MDS also indicated use of a high-risk hypoglycemic medication. Review of Resident #36's Care Plan initiated on 12/29/2025, revealed Resident #36's Do Not Resuscitate status, Resident #36's use of medication related to depression and insomnia with specific medications listed, activities of daily living (ADL), pain medication usage with specific medication listed, diuretic therapy related to high blood pressure, and nutritional problems related to diet. Interventions included black box warnings, assistance as needed with activities, monitor for choking and pocketing foods. The care plan did not mention any focus on diabetes or list any interventions for diabetes. Review of Resident #36's Physician Orders dated 12/29/2025, revealed the following active orders: -Low Concentrated Sugars (LCS)-Fast-acting insulin given per sliding scale (depending on how elevated Resident 36's blood sugars were.)-Slow acting insulin to be administered every morning. Review of Medication Administration Record-Treatment Administration Record (MAR-TAR dated for the month of April 2026, revealed Resident #36 received 35 units of insulin subcutaneously every morning for diabetes type 2 with hyperglycemia. Resident #36 also received fast acting insulin each day at 7:30 AM, 11:00 AM, 4:00 PM, and 8:00 PM per sliding scale, if required by Resident #36's blood sugar levels. Fast acting insulin was administered approximately 51 times in April from 04/01/2026 through 04/21/2026 During an interview on 04/22/2026 at 12:40 PM, Registered Nurse (RN) #4 indicated that the Care Plan was what staff reviewed to know how to care for residents. RN #4 indicated the Care Plan should be specific in listing diagnoses and interventions to help the residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/23/2026 at 11:35 AM, the Director of Nursing (DON) stated the Care Plans should be checked and updated with all MDS assessments. The DON indicated that the MDS triggers things that should be included on the resident's Care Plan. The DON stated, The care plan has basic things first such as the residents code status to activities of daily living to certain medical diagnosis like diabetes, congestive heart failure, falls, or hypertension. During an interview on 04/23/2026 at 2:00 PM, the Administrator indicated there have been several issues with the MDS being updated and the Care Plans being person-centered. The Administrator indicated completing the MDS and updating the residents Care Plan was part of Quality Assurance. The Administrator indicated a Care Plan could include pretty much anything ranging from a resident's risks, accidents, medications, and diagnosis, and were to be updated with any changes with the residents. During an interview on 04/21/2026 at 9:54 AM, the MDS Consultant indicated that a full time MDS Coordinator was recently hired, and on 04/06/2026 the MDS Coordinator conducted direct observations and interviews with residents and direct care staff and updated all Care Plans accordingly. Review of a facility undated policy titled, Comprehensive Care Plan indicated, Each resident will have a person-centered comprehensive care plan developed and implemented to meet their holistic preferences and goals and address the resident's nursing, medical, physical, mental and psychosocial needs identified in the comprehensive assessment and This facility will help develop and implement a comprehensive person-centered care plan for each resident that includes: a. Measurable objectives and time frames to meet the residents medical, nursing and mental/psychosocial needs that are identified in the comprehensive assessment utilizing the RAI process, evidence-based criteria, and professional standards.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and facility policy review, it was determined that the facility failed to ensure that antibiotic medications were administered promptly and as ordered, and that the accuracy of orders entered into a resident's electronic health record was verified for one (Resident #76) of one resident reviewed for medication administration. Specifically, the facility failed to ensure ordered antibiotics were not left in the medication room's overflow box for seven days prior to initiating administration, and to ensure the duration of the antibiotics were entered as ordered. The findings include: Review of Resident #76's Medical Diagnosis report revealed, the facility admitted Resident #76 with diagnosis that included chronic obstructive pulmonary disease (COPD) [damage to the airways causing inflammation and other problems that block airflow and make it hard to breath]; urinary tract infection (UTI) [infection in any part of the urinary system]. Review of an Order Summary revealed, Resident #76 had an active order for two antibiotics (medication given for an infection) twice a day with a start date of 04/17/2026. One antibiotic was ordered for 10 days, and the other antibiotic was ordered for 14 days. On 04/21/2026 at 8:03 AM, this surveyor observed Resident #76 was not given one of the ordered antibiotics during medication administration by LPN #12. On 04/21/2026 at 11:25 AM, this surveyor observed medications for Resident #76 that were on the medication cart for administration. One ordered antibiotic was not present on the medication cart for administration. During an interview on 04/21/2026 at 2:00 PM, when asked why the ordered antibiotics were not being administered, Registered Nurse (RN) Supervisor #6 indicated that Resident #76's antibiotics were only to be given for a period of two days for one antibiotic and three and a half days for the other antibiotic, as opposed to the durations of 10 and 14 days that had been entered into the resident's health record. RN Supervisor #6 stated that she thought medication was for the normal time of 10 days when it was reported to her that the medication had arrived in the facility. RN Supervisor #6 stated she did not verify the duration of the order for the antibiotic before writing the order into the resident's health record. Review of a Pharmacy Medication Sheet sent from the Pharmacy revealed two different antibiotics were delivered to the facility on [DATE] at 5:50 PM and signed by Licensed Practical Nurse (LPN) #11 as acknowledgement of medications received. During an interview on 04/21/2026 at 2:37 PM, Pharmacist #2 revealed that on 04/10/2026 two different antibiotics were sent to the facility for Resident #76 following a hospital visit. One had a quantity of four tablets with directions to administer one tablet twice day for two days, the other antibiotic had a quantity of seven tablets with directions to administer one tablet twice a day until gone. Review of Resident #76's Medication Administration Record revealed the order for the two prescribed antibiotics did not begin to be administered until 04/17/2026, seven days following their delivery to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility. During an interview on 04/21/2026 at 3:12 PM, the Director of Nursing (DON) revealed that a night shift nurse put the antibiotics in the overflow box in the Medication Room when they were delivered to the facility and did not put in an order for the medications, or find out what the medication was for. The DON stated the medications were not administered until another nurse found the medication in the overflow box and took it to the RN Supervisor. During interview on 04/21/2026 at 9:42 PM, Licensed Practical Nurse (LPN) #11 stated that Resident #76's medication arrived at the facility from the pharmacy on 04/10/2026 at around 6 PM and that she had signed for it, acknowledging receipt of this medication. LPN #11 stated the process for when medications were delivered to the facility, the receiving nurse would put the medication in the overflow box in the medication room. Later in the night, they would take the medication and compare the medication with the Physicians Order and Medication Administration Record (MAR). LPN #11 revealed she did not remember if she took Resident #76's medications and put them in the medication cart or not.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, record review and facility policy review, it was determined that the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for one (Resident #83) of three residents reviewed for accidents. Specifically, the facility failed to follow the person-centered care plan interventions for Resident #83, resulting in an accident. The findings include: Review of an admission Record revealed the facility admitted Resident #83 on 08/15/2025 with diagnoses that included brain cancer, heart failure, need for assistance with personal care, muscle wasting and atrophy, abnormalities of gate and mobility, cognitive communication deficit, infection following a procedure at surgical cite, repeated falls, syncope and collapse, and fracture to left femur. Review of a discharge return anticipated Minimum Data Set (MDS), with an Assessment Reference Date of 10/25/2025, revealed Resident #83 had a Brief Interview for Mental Status score of 3, which indicated the resident had severe cognitive impairment. The MDS revealed Resident #83 was dependent on staff for toileting hygiene and required substantial/maximal assistance for toilet transfers and sit to stand motion Review of a documented titled CMS's RAI Version 3.0 Manual Section GG, dated 10/2025, revealed toileting hygiene consisted of managing clothing, including briefs, adjusting clothing, and perineal cleaning. Review of Resident #83's Care Plan initiated on 10/30/2025, revealed the resident had limited physical mobility due to a fracture to the left femur. Interventions included Resident #83 required extensive assistance from two staff members for toileting. Resident #83 was incontinent of bowel and bladder and wore a brief. Staff were to provide incontinent care and hygiene with each incontinent episode. The Care Plan also revealed Resident #83 was at risk of falls due to gait and balance problems. Interventions included a safe environment with even floors, a working a reachable call light, bed in lowest position, and handrails on walls. Review of an Incident and Accident (I&A) report, dated 11/13/2025, revealed a written statement from Certified Nursing Assistant (CNA) #7 that indicated on 11/12/2025 she took Resident #83 to their room to change the resident's brief. She asked Resident #83 if the resident was able to stand. Resident #83 stated yes. CNA #7 had Resident #83 stand, and she pulled the brief and soiled pants down then had Resident #83 return to a seated position. CNA #7 reported when Resident #83 stood back up for the last time Resident #83 lost balance and fell to the floor landing on their buttocks and hand. The I&A Report also included a typed statement obtained from Resident #83 that stated, The CNA stood me up to change me, she lost her grip and I fell. During an interview on 04/21/2026 at 8:50 AM, the Nurse Educator indicated that she trained all the new CNAs upon hire. She stated she taught the CNA's how to access the Care Plan in the electronic health record, and she trained them one on one with certain things. such if a CNA seemed to be struggling in an area. The Nurse Educator indicated if a resident allowed you to change them, you should change them in their bed or in their bathroom because there was a bar in the bathroom the residents could grab for safety. The Nurse Educator indicated she had instructed CNA #7 multiple (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times on transferring residents safely. During an interview on 04/23/2026 at 3:30 PM, Registered Nurse (RN) #6 indicated 11/12/2025 CNA #7 reported she was changing Resident #83 in the room and Resident # 83 fell. RN #6 indicated CNA #7 was the only CNA in the room and that she was attempting to change Resident #83 in the room instead of in the bathroom. During an interview on 04/23/2026 at 11:10 AM, Nursing Aid (NA) # 8 stated she was in NA school in the facility and had been taught to change residents in the bathroom if they were able to stand, to allow them to grab the bar so that the resident could support themselves. During an interview on 04/23/2026 at 11:16 AM, CNA #9 reported that the Nurse Educator taught her to change residents in the bathroom if a resident was able to stand and grab the bar for support. CNA #9 stated, training was completed before and after the incident of Resident #83's fall on 11/12/2025. CNA#7's training dates were initiated on 10/22/2025 and 11/25/2025. During an interview on 04/23/2026 at 11:25 AM, CNA #10 stated Resident #83 was a two-person assist. CNA #10 stated, Two people had to transfer [the resident] to be safe. Resident #83 was never changed by one person, it was always two. CNA #10 stated if a resident refused to lay down to be changed but could stand she would do it with a second person present. During an interview on 04/23/2026 at 11:35 AM, the Director of Nursing (DON) indicated she was not present on the day of Resident #83's fall. The DON stated that the Nurse Educator instructed every CNA on how to properly transfer a resident. During an interview on 04/23/2026 at 2:00 PM, the Administrator indicated CNA#7 attempted to change Resident #83 in the middle of the room and Resident #83 lost balance and fell. The Administrator indicated it was the Nurse Educator's responsibility to train all CNA staff. The Administrator indicated CNA #7 was terminated on 02/19/2026 following a written warning on 02/18/2025 related to similar incidents as Resident #83's incident on 11/12/2025. Review of CNA #7's Employee file on the Employee Disciplinary Action Form for CNA #7 indicated on 02/18/2026 CNA #7 was given a written warning due to work quality, safety and multiple incidents involving falls with residents. Review of a CNA New Hire Check List provided by the Nurse Educator on 04/21/2026 at 8:50 AM revealed that all CNAs on hire were taught how to access the Care Plan located on the electronic health record for each resident. Review of a Duties and Check Off of CNA dated 10/22/2025 and 11/25/2025 revealed, CNA #7 was trained to dress and undress a resident and assist a resident to the bathroom. A review of the document titled In-Service Training report-Transfer a Resident (Gait Belt) dated 11/13/2025, Department: Nursing (CNA) an in-service was completed by the Nurse Educator that addressed How to transfer a resident to the bathroom, to bed or change their clothing. Do not ask the resident. Always find the right way to transfer a resident before you do anything. Ask another CNA or nurse to help you with the resident transfer. Always use a gait belt. Review of a facility undated policy titled Accidents revealed, The facility must ensure that: Each (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident receives adequate supervision and assistance devices to prevent accidents. And The intent of this policy is to ensure this facility provides and environment that is free from accident hazards over which the facility has control and provides supervision. And Individualized person -centered interventions will be implemented, including adequate supervision and assistant devices to reduce risk related to hazards in the environment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and facility policy review, it was determined that the facility failed to ensure that all drugs and biologicals used in the facility were labeled in accordance with professional standards, including expiration dates and with appropriate accessory and cautionary instructions for one (Resident #36) of three residents reviewed. The findings include: Review of an admission Record revealed that the facility admitted Resident #36 on [DATE] with diagnoses that included type 2 diabetes with elevated blood sugars, congestive heart failure, chronic kidney disease, Alzheimer's, high blood pressure, and cognitive communication deficits. Review of Resident #36's admission Minimum Data Set (MDS), with an Assessment Reference Date of [DATE], revealed Resident #36 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact and was independent for daily decision making. The MDS indicated Resident #36 used a wheelchair for ambulation with no impairments to arms or legs. Active diagnosis listed on the MDS included coronary artery disease, heart failure, hypertension, kidney failure, and diabetes mellitus. The MDS indicated insulin injections were administered seven out of the seven days assessed during the look back period. Resident #36's MDS also indicated use of a high-risk hypoglycemic medication. Review of Resident #36's Physician Orders dated [DATE], revealed the following active orders: -Low Concentrated Sugars (LCS)-Fast-acting insulin given per sliding scale (Depending on how elevated Resident #36's blood sugars were.)-Slow acting insulin to be administered every morning. Review of Resident #36's Lab Report dated [DATE] indicated Resident #36's Glucose level was high. Resident #36's reading was 143 mg/dl. The normal reference range was 74-109 mg/dl. Review of Resident #36's Medication Administration Record-Treatment Administration Record (MAR-TAR) dated for the month of [DATE], revealed Resident #36 received 35 units of insulin subcutaneously every morning for diabetes type 2 with hyperglycemia. The MAR/TAR revealed insulin was administered every morning, including [DATE]th, 19th, 20th and 21st as indicated by the signatures of the nursing staff. Resident #36 received fast acting insulin as well each day at 7:30 AM, 11:00 AM, 4:00 PM, and 8:00 PM. On [DATE] Resident #36's blood sugars ranged from 103-266 with insulin required ranging from 2-6 units. On [DATE] Resident #36's blood sugars ranged 88-220 with insulin required ranging from 2-4 units. On [DATE] Resident #36's blood sugars ranged 142-257 with insulin required ranging from 2-6 units. On [DATE] Resident #36's blood sugar ranged 132-344 with insulin required ranging from 4-8 units. During an observation on [DATE] at 8:16 AM an insulin box labeled with Resident #36's name and date of birth , with a written date of [DATE] indicated as an opened date for the vial of insulin inside the box. During an interview on [DATE] at 8:16 AM, Licensed Practical Nurse (LPN) #1 indicated the insulin dated [DATE] belonged to Resident #36. LPN #1 stated the date of [DATE] indicated the day the vial (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was first opened and initiated use. LPN #1 reported the last administered dose was completed by LPN #1 on [DATE] during the morning medication pass. LPN #1 indicated the insulin should have been discarded and not administered after 28 days from the opened date. LPN #1 indicated night shift nurses check carts for expired medication nightly but that she should have checked the vial prior to administering the insulin. LPN #1 indicated if the insulin was administered after the 28th day it could cause the blood sugar to not be in control and cause other symptoms or illnesses. During an interview on [DATE] at 11:35 AM, the Director of Nursing (DON) indicated insulin vials should not be used after the 28th day of being opened. The DON indicated all nurses were ultimately responsible for checking the expiration dates on medication prior to administering them. The DON stated, insulin being administered after the 28th day could be an ineffective treatment for blood sugar levels and cause a lot to go wrong. During an interview on [DATE] at 2:00 PM, the Administrator stated, We definitely have to follow all the guidelines on the medications, and we can always contact our pharmacy consultant. During an interview on [DATE] at 9:50 AM, Pharmacist #2 indicated no insulin should be used past the 28th day after opening. All insulin vials were good for administration for 28 days. During an interview on [DATE] at 9:58 AM, Pharmacist #3 stated, It is the law from the manufacturer not to use an insulin multi dose vial after the 28th day once opened. Pharmacist #3 indicated after multiple sticks to an insulin vial; air gets into a vial and the more frequently a vial of insulin is exposed to light the more it loses effectiveness. Review of a facility's undated policy titled Storage of Medication revealed, No discontinued, outdated or deteriorating medications are to be used in this facility. All such medications are destroyed according to facility policy. and Multi-dose vials that have been opened or accessed should be dated and discarded within 28 days of opening/initial access unless the manufacturer specifies a shorter or longer date. Review of a document titled [Name Brand] Manufactures Insert dated 11/2018 revealed Storage, 10ml vial of [Name Brand] in-use(opened) can be used for 28 days refrigerated or at room temperature. And Do not use [Name Brand] after the expiration date stamped on the label or 28 days after you first used it. And The [Name Brand] vials you are using should be thrown away after 28 days, even if it still has insulin left in it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045477	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monette Manor, LLC	669 Hwy 139 North Monette, AR 72447

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, record review and facility policy review, it was determined that facility staff failed to wear proper Personal Protective Equipment (PPE) while providing direct care to a resident that had an indwelling catheter in place and was on Enhanced Barrier Precautions (EBP) for one (Resident #11) of one resident reviewed for Infection Control. The findings include: Review of Resident #11's Medical Diagnosis revealed the facility admitted Resident #11 with diagnosis that included Urinary Tract Infection (UTI) [bacteria in urinary tract] Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 01/26/2026, revealed Resident #11 had a Brief Interview for Mental Status score of 15 which indicated the resident was cognitively intact. Review of Resident #11's Care Plan initiated on 04/17/2026, revealed Resident #11 had EBP in place due to indwelling catheter. Care Plan interventions included appropriate PPE to be worn by staff. Review of an Order Summary revealed Resident #11 had an order for EBP in place related to indwelling catheter with a start date of 04/17/2026. The Order Summary also revealed an order for indwelling catheter output every day and night shift for indwelling catheter placement related to Extended Spectrum Beta-Lactamase (ESBL) [group of bacteria that commonly cause infections] in urine with a start date of 04/14/2026. Review of a Progress Note dated 04/14/2026 at 9:23 PM revealed, Resident #11 had an indwelling catheter placed. Review of a Progress Note dated 04/15/2026 revealed, Resident #11 continued on EBP due to indwelling catheter in place. During an observation on 04/22/2026 at 11:29AM, this surveyor observed a green dot which indicated EBP precautions, outside Resident #11's room on the nameplate beside the door and appropriate PPE on a supply cart in the hall. Certified Nursing Assistant (CNA) #5 was observed in Resident #11's room getting Resident #11 dressed without proper PPE on, such as a gown. During concurrent interview and observation on 04/22/2026 at 11:40 AM, Registered Nurse Supervisor (RNS) #6 was observed in Resident #11's room assisting with transfer of Resident #11 from bed to chair with mechanical lift without proper PPE on, such as gown or gloves. the Director of Nursing (DON) was present with this surveyor in Resident #11's room while RNS #6 transferred Resident #11. The DON stated, staff was not wearing proper PPE due to Resident #11 having an indwelling catheter while providing direct care to the resident. During an interview on 04/22/2026 at 3:31 PM, CNA #5 stated staff would know when a resident was on EBP by a green dot on name plate outside of door. CNA #5 revealed Resident #11 was on EBP due to having an indwelling catheter and she should have put on a gown when providing direct resident care. During an interview on 04/23/2026 at 11:44 AM, The DON revealed that PPE should be worn every (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time staff go into a resident's room that was on EBP. The DON also stated that when proper PPE was not worn infections could spread throughout the facility. Review of in-service provided on 04/17/2026 covering EBP for CNAs revealed that EPB in addition to standard and contact precautions will be implemented during high contact resident care activities when caring for a resident that have increased risk for acquiring a resistant MRDO. CNA #5's signature was on the sign-in sheet for this in-service. Review of a facility policy titled Enhanced Barrier Precaution revealed Enhanced Barrier Precautions expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of Multidrug resistant organisms (MRDO) to staff hands and clothing. High contact resident care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of a device- central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care. Enhanced Barrier Precautions apply to wounds and/or indwelling medical devices (i.e., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status.