STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115144	A. Building B. Wing	03/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverdale Center for Nursing and Healing	315 Upper Riverdale Road Riverdale, GA 30274

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and review of the facility policy titled Food Receiving and Storage, the facility failed to ensure that opened food items in the dry storage area were properly labeled and dated. In addition, dietary staff failed to ensure that opened food items were properly refrigerated. This deficient practice had the potential to place the 130 residents receiving nutrition and hydration from the kitchen at risk of foodborne illness. Findings include: Review of the facility policy titled Food Receiving and Storage, dated April 2024, revealed the Guidelines section included, . 6. Dry foods that are stored in bins will be removed from original packing, labeled, and dated. 7.All foods stored in the refrigerator or freezer will be covered, labeled, and dated. Observation on 03/13/2026 at 08:35 AM of the dry storage area revealed a five-pound bag of grits that had been opened with no date, and a three-pound box of potato pearls opened with no open date. During an interview on 03/13/2026 at 10:55 AM, the Dietary Manager (DM) confirmed that the open bag of grits and open box of potato pearls had no open date. The DM confirmed that the date on each that is in black marker was the date the food item was delivered to the facility. The DM revealed that dietary staff are to date any opened/used food items before placing them in the storage area. The DM stated that he generally conducted rounds and checked for issues, such as undated food items. Observation on 03/15/2026 at 10:05 AM in the dry storage area revealed a large, clear, resealable plastic bag containing egg noodles. The egg noodles had been removed from their original packaging. This bag had no label and had a date of 09/13/2026 in black marker. Continued observation of the dry storage area revealed a one-gallon container of cole slaw dressing that had been opened and partially used, stored on the shelf, and not refrigerated. The opened cole slaw dressing did not have an open date. During an interview on 03/15/2026 at 10:05 AM, the DM confirmed that the egg noodles had been removed from their original packaging and were not properly labeled or dated. The DM stated that the date 09/13/2026 on the plastic bag is their use-by date. The DM confirmed that the partially used gallon container of cole slaw dressing was stored in the dry storage area and was neither refrigerated nor marked with an open date. The DM revealed that dietary staff should have dated any opened food items and that the opened cole slaw dressing should have been stored in the refrigerator, not the dry storage area.

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on observations, staff interviews, record review, and review of the facility's policy titled Medication Administration, the facility failed to ensure that residents' medications were free from misappropriation by licensed nursing staff during medication administration observations.Findings include: A review of the facility's policy titled Medication Administration, revised 04/2025, revealed the Policy Explanation and Compliance Guidelines section included . 12. Compare medication source (bubble pack, vial, etc.) with MAR [medication administration record] to verify resident name, medication name, form, dose, route, and time.Review of the MAR for R45, dated 03/01/2026 - 03/31/2026, revealed an order for metoprolol succinate oral capsule extended release (ER) 24-hour sprinkle 25 milligram (mg), give 25 mg by mouth one time a day for hypertension (high blood pressure). Review of the MAR for R92, dated 03/01/2026 - 03/31/2026, revealed an order for metoprolol tartrate oral tablet 25 mg, give one tablet by mouth two times a day. Observation during medication administration for R45 on 03/14/2025 at 9:02 AM revealed that Licensed Practical Nurse (LPN) HH stated that R45's metoprolol ER 25 mg was not available on the medication cart. Continued observation and interview at 9:03 AM revealed LPN HH stated she would obtain the medication from R92's medication packet since he was ordered the same medication. LPN HH removed the medication from the pill card of R92 and placed it in a medicine cup. Further observation at 9:04 AM revealed LPN HH administered the metoprolol tartrate oral tablet 25 mg from R92's medication supply to R45. In an interview on 03/14/2025 at 9:50 AM, near the nurses' station on the East Wing, Unit Manager GG stated that LPN HH should not have administered medication to R45 from another resident's medication card. Unit Manager GG further stated that the protocol was to obtain the correct medication from the back-up medication dispensing system. In an interview on 03/14/2025 at 11:20 AM, the Director of Nursing (DON) stated that if a resident's medication was not available, the nurse should obtain it from the facility's backup medication-dispensing system, and if it was not available in the backup system, the nurse should call the pharmacy.

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on record review, staff interviews, and review of the facility policy titled MDS 3.0 Completion, the facility failed to complete a Minimum Data Set (MDS) comprehensive assessment for one resident (R) (R70) out of 57 sampled residents.Findings include: Review of the facility policy titled MDS 3.0 Completion, with a reviewed/revised date of 10/2025, revealed the Policy Explanation and Compliance Guidelines section included 1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate, and standardized assessment of each resident's functional capacity, using the RAI specified by the State. 2. c. Annual Assessment - a comprehensive assessment completed using an ARD no >366 days from the most recent prior comprehensive assessment and no >92 days from the most recent quarterly assessment (counting ARD to ARD). Review of R70's electronic medical record (EMR) admission Record revealed an admission date of 02/18/2024, with diagnoses including, but not limited to, bradycardia, epilepsy, and vascular dementia. Record review for R70 Clinical-MDS revealed the facility last completed a full comprehensive MDS assessment on 01/24/2025. An interview on 03/14/2026 at 1:57 PM with MDS Coordinator II revealed that a comprehensive assessment was not completed for R70 in February 2026. She stated that the previous MDS Coordinator failed to complete the comprehensive assessment for R70. The MDS Coordinator stated she will complete R70's annual comprehensive assessment. An interview on 03/14/2026 at 2:10 PM with the Administrator stated that the MDS department should follow the Resident Assessment Instrument (RAI) Manual for guidance. An interview on 03/15/2026 at 10:00 AM with the MDS Coordinator II explained that the facility has a system in place to ensure assessments are conducted in accordance with the specified timeframes for each resident. MDS Coordinator II stated that when a resident is admitted to the facility, an entry tracking assessment is completed, and further MDS assessments are driven by the resident's insurance (payor source) type. She stated that the MDS department should refer to the MDS Clinical List, and that, under the MDS tab, it will identify which assessment and when it is due.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility policy titled MDS 3.0 Completion, the facility failed to accurately reflect the status on the Minimum Data Set (MDS) assessments for two of 57 sampled residents (R) (R70 and R1). Findings include: Review of the facility policy titled MDS 3.0 Completion, with a reviewed/revised date of 10/2025, revealed the Policy section included, Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. 1. Review of R70's electronic medical record (EMR) admission Record revealed an admission date of 02/18/2024, with diagnoses including, but not limited to, bradycardia, epilepsy, and vascular dementia. Review of the quarterly MDS assessment for R70, dated 01/19/2026, revealed that section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 2 (indicating severe cognitive impairment). Section J (Health Conditions) documented that the resident was assessed as having no falls. Review of the Facility Incident Form Report dated 12/06/2025 revealed that R70 fell, was unresponsive, did not respond to commands, 911 was called, and the resident was transported to the hospital. The unwitnessed fall was substantiated. In an interview on 03/14/2026, R70 stated he had fallen in the past and had gone out to the hospital once. The resident stated he has not had any recent falls. In an interview on 03/14/2026 at 10:55 AM, Licensed Practical Nurse (LPN) JJ stated R70 had sustained two unwitnessed falls. She stated the resident was sent out to the hospital in December 2025 for a fall and possible seizure activity. In an interview on 03/14/2026 at 1:57 PM, the MDS Coordinator confirmed that R70 had a fall on 12/06/2025. She confirmed that, in the quarterly MDS assessment on 01/19/2026, Section J falls was not accurately coded for R70. The MDS Coordinator stated she would make the necessary correction to R70's quarterly MDS assessment of 01/19/2026. 2. Review of the facility's EMR revealed R1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to, peripheral vascular disease. Review of the quarterly MDS assessment for R1, dated 12/18/2025, revealed that section C (Cognitive Patterns) documented a BIMS score of 15 (indicating intact cognition). Section P (Restraints and Alarms) documented R1 used bed rails daily. Review of the care plan for R1, dated 12/21/2025, documented no focus area for the use of restraints. Review of the physicians' orders for R1 documented no order for restraints. Observation on 03/13/2026 at 10:31 AM revealed R1 lying in bed. Observation revealed there were no bed rails on R1's bed. Observation on 03/14/2026 at 8:40 AM revealed R1 sitting up in bed watching television. Observation (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed there were no bed rails on R1's bed. Observation on 03/15/2026 at 1:31 PM revealed R1 in his room watching television and listening to music. Observation revealed there were no bed rails on R1's bed. In an interview on 03/14/2026 at 8:44 AM, R1 stated that he did not have bedrails on his bed and was able to transfer without them. In an interview on 03/14/2026 at 8:49 AM, the MDS Coordinator confirmed that the MDS assessment for R1, dated 12/18/2025, incorrectly documented the use of bedrails. She stated that if there were no bed rails on the bed, the MDS should not document that the resident used bed rails. In an interview on 03/14/2026 at 9:36 AM, Unit Manager (UM) GG stated R1 did not use bed rails. She stated that an audit was recently conducted on residents with and without bedrails, and the results were given to the MDS Coordinator to update the residents' MDS. She confirmed there were no physicians' orders for bed rails for R1, and that R1 did not need or use bedrails. In an interview on 03/15/2026 at 11:56 AM, the Administrator stated her expectations were for the MDS assessments to be timely and accurate. She stated that the facility conducted a bedrail in February 2026, and the audit results were sent to her and the MDS Coordinator.

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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 record review and staff interviews, the facility failed to ensure one of 57 sampled residents (R) (R36) received restorative care services as recommended by therapy staff. This deficient practice had the potential to place R36 at risk of unmet needs and a diminished quality of life. Findings include: Review of the clinical record revealed R36 was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, contractures of the right and left hands, contractures of right and left knees, contractures of right and left ankle, contractures of right and left foot left hand. Review of the significant change Minimum Data Set (MDS) assessment for R36, dated 02/12/2026, revealed section GG (Functional Abilities and Goals) documented R35 was dependent on staff for all activities of daily living (ADL's). Review of the occupational therapy (OT) discharge documentation revealed R36 was discharged from services on 06/08/2025. The OT document stated, Discharge Recommendations restorative. During an interview on 03/15/2026 at 12:00 PM, the Assistant Director of Nursing (ADON) stated that she was responsible for the facility's restorative care program. The ADON stated that R36 was currently not receiving restorative care. She stated that once a resident is discharged from therapy services, therapy would make recommendations if restorative services were needed. During an interview on 03/15/2026 at 12:15 PM, the Director of Therapy (DT) revealed that R36 was last seen and discharged from physical therapy and occupational therapy on 06/09/2025. The DT reviewed the OT discharge documentation and confirmed that the OT recommended R36 to receive restorative care post-discharge from therapy services. The DT stated that once the OT marked the recommendations for restorative services therapy, staff completed a paper form indicating the required care needs, and that form was handed to her. The DT stated that she reviewed the form, placed the resident's name on a list, and that list was provided to the ADON, who is responsible for the restorative program. Continued interview with the DT revealed that she was unable to locate the paper form that the occupational therapist should have completed. The DT stated that the OT should have completed the paper form and provided it to her when R36 was discharged from therapy services. The DT revealed that therapy staff did not follow the proper process for ensuring a resident is placed on the list to receive restorative services. During an interview on 03/15/2026 at 12:40 PM, the ADON revealed that a resident can receive restorative services without a therapy consultation. The ADON stated that if a Certified Nursing Assistant (CNA) noticed that a resident had a decrease in mobility, they could recommend restorative services. The ADON stated that once nursing staff recommends a resident for restorative services, the team, consisting of nurses, the Director of Nursing (DON), ADON, and therapy staff, discusses whether restorative services would be beneficial for the resident during the morning meeting. The ADON stated that if a CNA notices a resident in need of restorative services, they should report it to the charge nurse, who should then notify the DON to add the resident to the list for discussion during the morning meeting. The ADON revealed that R36 had not been discussed during the meetings regarding receiving restorative services. During an interview on 03/15/2026 at 12:50 PM, CNA MM revealed that R36 was currently not receiving restorative services. The CNA stated that if she notices a resident with decreased mobility, she would notify the charge nurse. The CNA stated she has notified the charge nurse that R36 has mobility issues. During an interview on 03/15/2026 at 1:10 PM, Licensed Practical Nurse (LPN) GG stated that she was the charge nurse for the unit where R36 resides. LPN GG stated that she assumed R36 was receiving restorative services. Continued interview revealed that she does not recall the CNA notifying her of R36's decrease in mobility.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and a review of the facility policy titled Hospice Services Facility Agreement, the facility failed to maintain communication and coordination of care with hospice for one of six residents (R) (R7) receiving hospice palliative care services. This deficient practice had the potential to place R7 at risk of unmet care needs. Findings include:A review of the facility policy titled Hospice Services Facility Agreement, last reviewed/revised date of September 2023, revealed that, It is the policy of this facility to provide and/or arrange for hospice services to protect a resident's right to a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the facility. The facility has a designated Director of Nursing to be responsible for working with hospice representatives to coordinate care to the resident provided by the facility and hospice staff. The designated member of the facility working with hospice representative is responsible for: (A) collaborating with hospice representatives and coordinating LTC facility participation in the hospice care planning process for those residents receiving services. (B) 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 resident and family. (D) Obtaining the following information from hospice: (i) The most recent hospice plan of care specific to each resident. (E) Ensuring that the facility provides orientation to hospice staff on the following: (iv) record-keeping requirements. The facility will, under a written agreement, 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 facility to attain or maintain the resident's highest practicable physical, mental, and psychological well-being.Review of the electronic medical record (EMR) revealed that R7 was admitted to the facility on [DATE] with diagnoses including, but not limited to, senile degeneration of brain, eosinophilic esophagitis, type 2 diabetes mellitus, long-term use of antithrombotic /antiplatelet, depression, essential hypertension, vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, history of other venous thrombosis and embolism, contracture, right knee, contracture, left knee, contracture, left hand, and vitamin d deficiency.Review of the physician orders revealed that R7 was admitted to hospice on 09/06/2024 due to the diagnosis of senile degeneration of the brain. Review of the annual Minimum Data Set (MDS) assessment for R7, with an Assessment Review Date (ARD) date of 01/23/2026, revealed that R7 presented with a Brief Interview for Mental Status (BIMS) score of zero, indicating that the resident is rarely or never understood, and that R7 was receiving hospice care.A review of the Hospice Care Plan created by the facility, dated 02/26/2026, revealed that R7 began receiving hospice services on 09/06/2024. It was noted that the resident would experience the highest quality of life throughout their life journey; that the facility staff would notify hospice of significant changes, clinical complications needing (plan of care) change, the need to transfer the client, and/or death; the facility would assess for pain, restlessness, agitation, constipation, and other symptoms of discomfort; the facility would medicate as ordered and evaluate effectiveness; the facility would provide non-pharmacological approaches to aid in decreasing discomfort; that bereavement service would be provided by hospice (as needed) to help with grief and loss; and that support to the resident and family would be provided, including caregivers and other residents, before and after death. It was further noted that the hospice provider would provide over and beyond services, which include, but are not limited to, spiritual counseling, increased social services, increased clinical visits, and expanded pain/comfort control; provide emotional and social support to the patient and family to address anticipatory grief, end-of-life wishes/planning needs, and other identified items; and collaborative care with hospice staff.A review of the Hospice and Nursing Facility Services (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Agreement dated 8/28/2024 revealed, This Hospice and Nursing Facility Services Agreement is entered into as of this 28th day of August 2024 by and between (skilled nursing facility) and (Hospice company) for patient (R7). Section VII of the Service Agreement revealed that, hospice and skilled facility each agrees to cooperate with the other in revising the quality and appropriateness of Hospice services rendered in the Skilled Facility. To this end, Skilled Facility and Hospice will each appoint two individuals who, together, constitute a liaison committee which will meet, when appropriate, to review working relationships between Hospice and Skilled Facility to discuss services rendered to Residents who are Patients, and to make recommendations for improving the contractual agreement between the parties. Discussions and recommendations for improving the contractual agreement between parties. Discussions and recommendations of the Liaison Committee will be considered advisory to Skilled Facility and Hospice, and not binding upon either party. The written agreement will set out at least the following: d. a communication process, including how the communication will be documented between the facility and the hospice provider, to ensure that the needs of the resident are met 24 hours per day. It is further noted that, The facility has designated the Director of Nursing to be responsible for working with hospice representatives to coordinate care to the resident provided by the facility and hospice staff. On 03/14/2026 at 12:46 PM, R7 was observed in bed with some type of hand roll in her right hand and lying on the right side with a wedge behind her. The resident was nonverbal and unable to express her needs.During an interview on 03/14/2026 at 1:00 PM, Licensed Practical Nurse (LPN) JJ stated that they only have a facility care plan. She confirmed that there was no plan of care from the hospice provider coordinating or outlining the services they provide to R7. When asked how the facility staff would know what services the hospice staff provided, LPN JJ stated that all the information should be in the facility care plan.During an interview on 03/14/2026 at 1:10 PM, Registered Nurse (RN) KK stated that she checked the EMR, and there was no documentation of the interventions or services the hospice provided for R7. She confirmed that, at this time, she couldn't determine what hospice does or was responsible for. She stated she would not be able to inform the nursing staff if the resident had a shower, vitals, or any other services by hospice. She stated that the hospice provider does not have access to the facility's EMR and that they document in their own electronic system, which the facility staff does not have access to. During an interview on 03/14/2026 at 1:26 PM, the Director of Nursing (DON) confirmed that they did not have a hospice care plan or a hospice communication book. She stated that the hospice staff just verbally reports to the facility nursing staff on what they have done. She confirmed that they do not have a copy of the hospice plan of care, but they are reaching out to obtain it.During an interview on 03/14/2026 at 1:37 PM, R7 was observed in bed with Certified Nursing Assistant (CNA) LL assisting her with her meal. She stated that she was not assigned to care for R7, but she has cared for residents in the facility who are receiving hospice services. When asked how she knows what care or services are provided to a resident by hospice, she stated, We don't know. They sometimes will tell you when they are here, but sometimes we don't even know if they came or what they did.During an interview on 03/14/2026 at 1:37 PM, the Wound Care Nurse stated that she provided all wound care, including for residents receiving hospice services. She stated that the hospice provider does not do any wound care for R7. When asked how she would know if the hospice nurse was looking at the wound or measuring the residents' wounds, she stated, I just know. We do all that. During an interview on 03/14/2026 at 1:50 PM, CNA MM stated that the hospice aide comes in and gives the resident showers. She stated that sometimes she will help or just leave a towel on the bed, but that was pretty much all the aide does. She confirmed that she was not sure if that was written anywhere.During a telephone interview on 03/14/2026 at 2:40 PM, the Triage Hospice Nurse stated that he could only provide general information due to HIPAA (Health Insurance Portability and Accountability Act) laws. He stated that they have their own electronic medical record system for documenting care. He further stated that the hospice care manager comes out weekly, and the hospice staff should have verbal and written communication with the facility staff on the services (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided to the residents. He could not answer questions related to the specific means of communication of activities of daily living (ADL) care or nursing services provided by hospice staff. During an interview on 03/14/2026 at 2:56 PM, the Nursing Home Administrator (NHA) stated that the Social Worker (SW) was the designated Interdisciplinary Team (IDT) member responsible for communicating with hospice.During an interview on 03/14/2026 at 3:00 PM, the SW stated, We are not involved in hospice care planning. She stated that hospice has a CNA come in every day. She stated that the hospice provider has not had an SW, and if they have one, they have not been in the facility. The last time she spoke with the SW related to R7 was in November 2024. She was asked to confirm that there was no plan of care for R7; she stated, They have a plan of care. They come in and provide her hospice services. When asked what services, she stated that the plan of care is verbal communication. Unless it pertains to social services, she does not review the plan of care. During an interview on 03/15/2026 at 9:08 AM, the NHA confirmed that she had just received the hospice plan of care and the coordination of care documents from the hospice provider. She stated that the communication liaison was the facility's SW, but she was not sure of the communication process for hospice. She provided notes dating back to 2024 that the resident has been receiving hospice services. She confirmed that the hospice documentation for the coordination of care for R7 was retrieved on 03/14/2026.During an interview on 03/15/2026 at 9:55 AM, the DON stated that she had not read the hospice policy and was not involved in the care planning for residents receiving hospice services. She stated she did make sure that, when they are in the building, they check in. During an interview on 03/15/2026 at 10:05 AM, the NHA confirmed that the policy noted that the DON is responsible for the coordination of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115144	A. Building B. Wing	03/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverdale Center for Nursing and Healing	315 Upper Riverdale Road Riverdale, GA 30274

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policies titled Catheter Care and Infection Prevention and Control Program, the facility failed to follow infection control process during indwelling catheter care for one of 11 residents (R) (R1) with an indwelling urinary catheter. This deficient practice had the potential to place R1 at risk of avoidable infection due to cross-contamination.Findings include: Review of the facility's policy titled Catheter Care, revised October 2025, revealed Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use.Review of the facility's policy titled Infection Prevention and Control Program revised April 2025 documented Policy: This facility has established and maintains 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 as per accepted national standards and guidelines.Review of the facility's electronic medical records (EMR) revealed R1 was admitted to the facility on [DATE] and was readmitted [DATE] with a diagnosis that included, but was not limited to, retention of urine.Review of the quarterly Minimum Data Set (MDS) assessment for R1, dated 12/18/2025, revealed that section H (Bladder and Bowel) documented that R1 had an indwelling catheter.Review of the care plan for R1, dated 12/21/2025, documented R1 has a supra-pubic catheter related to (r/t) diagnosis (dx) of neurogenic bladder, retention of urine, bilateral hydronephrosis, obstructive and reflux uropathy, and benign prostatic hypertrophy (BPH). The goal was that R1 would show no signs or symptoms of a urinary infection and would be/remain free from catheter-related trauma through the review date. Interventions included cleaning the catheter stoma site as ordered, reporting any abnormalities to the physician, and enhanced barrier precaution in place.Review of the Physicians' Orders for R1, dated 02/20/2026, documented orders included, but not limited to, Supra Pubic Catheter 18_french (FR) with_10_cubic centimeter (cc) balloon to bedside straight drainage. May change when catheter is occluded, leaking or obtaining a new specimen, as needed for catheter change and every shift for care and as needed for care. Perform Supra Pubic Catheter Care with Soap and Water every day and evening shift for catheter care.Observation on 03/14/2026 at 11:25 AM of catheter care for R1 revealed Licensed Practical Nurse (LPN) FF did not wear a gown during the catheter care, she did not clean a pair of scissors she used to cut the old dressing from the indwelling urinary catheter before placing the scissors in her uniform pocket, and she did not clean the resident's bedside table after removing the wash basin from the bedside table she used for the catheter care. Further observations revealed that Enhanced Barrier Precaution (EBP) signage was on R1's room door, personal protective equipment (PPE) was accessible in the hallway near R1's room, and personal items were observed on R1's bedside table used during the catheter care procedure.In an interview on 03/14/2026 at 11:40 am, LPN FF confirmed she did not wear a gown during catheter care, did not clean the pair of scissors she used to cut the old dressing from the indwelling urinary catheter, and did not clean the resident's bedside table after removing the wash basin. She stated she should have worn a gown because the resident was on EBP, and she should wear a gown whenever certain procedures were done for the resident, which involved high contact. She stated that performing indwelling urinary catheter care was a high-contact procedure, and she should have worn a gown. She further stated that the gowns were available in the hallway across from the resident's room, and the EBP signage was on the door. LPN FF further stated she should have cleaned the resident's bedside table after removing the wash basin, and she should have cleaned the pair of scissors after cutting the old dressing on the catheter before placing it back into her pocket, because it could cause cross-contamination and infection for the resident. She confirmed the resident prefers to eat his meals in his room, and the meal tray would be placed on the resident's bedside table, so if the bedside table was not cleaned, the resident could (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	get an infection. She stated that if the scissors were not cleaned, she could reuse them on R1, and that would cause cross-contamination and spread of infection to R1.In an interview on 3/15/2026 at 7:33 AM, the Director of Nursing (DON) stated her expectations were for the staff to wear appropriate PPE, such as gloves and gowns, when performing catheter care because there could be cross-contamination and the residents could get infections. She stated that if the wash basins were placed on the residents' bedside tables, the staff needed to clean the tables since the residents use the bedside tables to eat, and they may consume contaminated foods or get an infection by touching the table. The DON further stated that whenever scissors were used to remove dressings, the scissors should not be placed in the staff's pockets before being cleaned, and they should be cleaned appropriately because they could cause cross-contamination and infection to the residents if they were used on the residents without being cleaned.In an interview on 03/15/2026 at 10:12 AM, the Infection Preventionist (IP) stated her expectations were for the staff to wear appropriate PPE when providing catheter care. She stated the staff needs to wear gowns and gloves for catheter care because the gown provides a barrier between the staff and the residents during care. The IP further stated that if gowns were not worn by the staff, bacteria could spread to the residents. The IP stated that when wash basins were used on the residents' bedside tables, the tables should be sanitized after use because the residents placed personal items on the bedside tables, so there was an increased risk of transferring infection to the residents. The IP further stated that scissors should be cleaned after use, and not placed in the staff's uniform pocket without being cleaned. The IP stated there could be a high risk of infection to the residents when the scissors were not cleaned.