STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115406	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wrightsville Manor Health and Rehab	337 West Court Street Wrightsville, GA 31096

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record review, the facility failed to ensure one of 22 sampled residents (R) (R4) was treated with dignity during dining and during the care of an indwelling urinary catheter. This failure had the potential to place R4 at risk of experiencing low self-esteem and embarrassment.Findings include:Review of the facility's Residents' Right to Care, Treatment, and Services, located in the facility's admission Packet, revealed, . Resident have [sic] the right to expect reasonable continuity of care. This care is given without discrimination in the quality of services based on the source of payment and with respect for personal dignity and privacy .Review of R4's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R4 was admitted to the facility on [DATE] with diagnoses that included pseudobulbar affect, generalized anxiety disorder, and abnormal weight loss.Review of R4's significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/14/2025 and located under the MDS tab of the EMR, revealed R4 was unable to complete the Brief Interview for Mental Status (BIMS), had long and short-term memory problems, and was severely impaired in cognitive skills for daily decision making. It was recorded that the resident had an indwelling urinary catheter and was dependent on staff for most activities of daily living (ADLs).a. During an observation on 7/28/2025 at 12:26 pm, R4 was observed lying in bed. Her noon meal tray was on her bedside table. At 12:38 pm, Certified Nurse Aide (CNA) 3 entered R4's room, repositioned R4 in bed, and began to feed the resident. CNA3 stood by the resident's side while feeding her. There was no chair in the room for CNA3 to sit in. CNA3 fed R4 her entire meal while standing at the resident's side.During an interview on 7/30/2025 at 2:01 PM, CNA3 confirmed that she stood by R4's side while feeding her on 7/28/2025. CNA3 stated that when residents were in their rooms for meal service, she always stood by the resident. CNA3 stated she did not know that standing by a resident while feeding them was a dignity concern. She stated she had probably been taught that, but it had slipped her mind.During an interview on 7/31/2025 at 1:27 pm, the Assistant Director of Nursing (ADON) was asked what the expectation was related to standing while feeding a resident. The ADON stated, I understand the dignity aspect for not standing over someone to feed them, but it is not something we have ever in serviced on, so we cannot have that expectation.b. During an observation on 7/30/2025 at 10:46 am, R4 was observed lying in bed. Her urinary catheter drainage bag was hanging on the side of the bed, and there was no dignity bag in place. The bag could be seen from the hallway and contained urine.During an observation on 7/31/2025 at 10:50 am, R4 was observed in the common area in front of the nurses' station. Her urinary catheter drainage bag and tubing were lying on the floor under her geriatric chair. The drainage bag was not covered with a dignity cover, and there was urine in the bag.During an interview and observation on 7/31/2025 at 10:53 am, CNA1 was asked why dignity covers were used with urinary catheter drainage bags. She stated it was a dignity issue. CNA1 was asked if R4's drainage bag was covered with a dignity cover at this time. CNA1 looked and the drainage bag and stated, No. CNA1 stated she had asked someone to find a dignity cover on the previous day.During an interview on 7/31/2025 at 10:59 am, the ADON stated the expectation was for urinary catheter drainage bags to be covered. The ADON went to the supply room, obtained a dignity cover, and instructed CNA1 to take the resident to her room, empty the drainage bag, and place the dignity cover on the bag.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the facility's policy titled, Transfer or Discharge, Preparing a Resident for, the facility failed to provide the resident and/or their responsible party (RP) a written transfer notice, including the resident's appeal rights and ombudsman contact information, at the time the resident was transferred to the hospital, and failed to send a copy of the notice to the Long Term Care Ombudsman for five of five residents (R) (R6, R7, R28, R71, and R76) reviewed for hospitalizations in a total sample of 22. This deficient practice had the potential to place R6, R7, R28, R71, and R76 and/or their RP at risk of not having the knowledge of where and why a resident was transferred and/or how to appeal the transfer, if desired, and had the potential to contribute to the possible denial of re-admission and loss of the resident's home following a hospitalization for residents transferred to the hospital. Findings include: Review of the facility’s policy titled, Transfer or Discharge, Preparing a Resident for, dated December 2016, indicated, Policy Statement: Residents will be prepared for discharge.Policy Interpretation and Implementation When a resident is scheduled for transfer…the business office will notify nursing services of the transfer…so that appropriate procedures can be implemented…Nursing services is responsible for: a. Obtaining orders for…transfer…f. Assisting with transportation as applicable (i.e. , calling for an ambulance) …The business office is responsible for: …b. Informing the resident, or his or her representative…of our facility's readmission appeal rights, bed holding policies, etc… 1. Review of R7’s Face Sheet located under the Profile tab of the EMR indicated R7 was admitted to the facility on [DATE]. Review of R7's Progress Note, dated 4/15/2025 and located in the Progress Notes tab of the EMR, revealed R7 was sent to the hospital on 4/15/2025. Review of R7 's EMR revealed no evidence that written notification regarding R7's transfer to the hospital was sent to R7’s RP or sent to the Ombudsman. Review of R7's, undated Bed Hold Notice, located in the EMR under the Miscellaneous tab, that the resident was sent to the hospital with, which did not have a signature from R7 or the RP and did not state the daily bed hold rate for a private or semi-private room. 2. Review of R71’s Face Sheet located under the Profile tab of the EMR revealed R71 was admitted to the facility on [DATE]. Review of R71's Progress Note, dated 7/2/2025 and located in the Progress Notes tab of the EMR, revealed R71 was sent to the hospital on 7/2/2025. Review of R71 's EMR revealed no evidence that written notification regarding R71's transfer to the hospital was sent to R71’s RP or sent to the Ombudsman. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R71's, undated Bed Hold Notice, located in the EMR under the Miscellaneous tab that was sent to the hospital with the resident, did not have a signature from R71 or the RP, and did not state the daily bed hold rate for a private or semi-private room. 3. Review of R76’s Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed R76 was admitted to the facility on [DATE]. Review of R76's Progress Note, dated 6/20/2025 and located in the Progress Notes tab of the EMR, indicated R76 was sent to the hospital on 6/20/2025. Review of R76 's EMR revealed no evidence that written notification regarding R76's transfer to the hospital was sent to R76’s RP or sent to the Ombudsman. Review R76's undated Bed Hold Notice, and located in the resident's EMR under the Miscellaneous tab, and that was sent with R76 to the hospital, did not have a signature from R76 or the RP, and did not state the daily bed hold rate for a private or semi-private room. 4. Review of R28's undated admission Record located in the EMR under the Profile tab, revealed R28 was admitted to the facility on [DATE] and was re-admitted on [DATE]. Review of the EMR Progress Notes, located under the Progress Notes tab, revealed a progress note, dated 7/10/2025, of Writer notified residents wife RP [Representative] [name] of [R28’s] transfer to [Name of Hospital] unit due to increased agitation and resident receiving IM [intramuscular] injection for agitation. Further review of the record revealed no documentation that written notification containing information as to the reason for the hospital transfer was provided to the resident or the RP. Additionally, there was no documentation that he resident and/or the RP was given written notice that specified the duration of the facility’s bed hold policy. 5. Review of R6's admission Record, located in the Profile tab of the EMR, revealed R6 was admitted to the facility on [DATE]. Review of R6's Discharge summary, dated [DATE] at 8:46 pm, revealed, . resident was displaying signs of altered mental status, barely responding nodding to questions that nurse (writer) asked him . notified sister . to see if she was in agreeance [sic] with sending him to the hospital . she agreed . Review of R6's Patient Transfer Form and Bed-Hold Notice, both dated 6/14/2025 and located under the Miscellaneous tab of the EMR, revealed no documented evidence that R6 or his RP were provided written notice of the transfer or that they were provided written notice of the facility's bed-hold policy at the time of transfer. The Bed-Hold Notice was marked that the resident wished to reserve his room, but did not identify the daily rate for holding the resident's room. Review of R6's Plan of Care Note, dated 06/18/2025 at 2:08 PM, revealed, . [R6] is expected to return from hospital hospital [sic] stay today. He was admitted to hospital on [DATE] for abdominal pain and decreased appetite due to AKI [Acute Kidney Injury] . (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/30/2025 at 10:45 am, the Administrator stated all RPs were notified by telephone by the nursing staff regarding a resident that must be transferred to the hospital. The Administrator confirmed the facility staff did send the RP written information on why the resident was sent to the hospital. The Administrator stated all residents transferred to the hospital were sent with a bed hold notice, but the RP was not provided with a bed hold notification. The Administrator also stated Medicaid residents had a seven-day bed hold, and if a resident was private pay, they could pay to hold the bed. During an interview on 7/31/2025 at 11:55 am, the Administrator revealed, We have no documentation of the reason for the transfer, and our bed hold policy having been provided to the resident, RP, and the Ombudsman regarding R28.” During an interview on 7/31/2025 at 3:35 pm, the Social Services Director (SSD) stated she was not aware she was supposed to send a notice to the Ombudsman regarding all residents who were transferred to the hospital.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and review of facility policy titled Foley Catheter Policy, the facility failed to manage a urinary catheter and drainage bag appropriately for one of one resident (R) (R4) reviewed for urinary catheters out of a total sample of 22 residents. This deficient practice had the potential to place R4 at risk of urinary tract complications.Findings include:Review of the facility's undated policy titled Foley Catheter Policy revealed that the policy did not address the proper placement of urinary catheter drainage bags and tubing.Review of R4's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R4 was admitted to the facility on [DATE] with diagnoses that included pseudobulbar affect, generalized anxiety disorder, and abnormal weight loss.Review of R4's Care Plan, located under the Care Plan tab of the EMR, revealed a focus of R4 having an indwelling urinary catheter. Goals included, . will show no s/sx [signs or symptoms] of urinary infection through review date . Interventions included to position catheter bag and tubing below the level of the bladder, check for kinks in catheter tubing, and resolve any issues to ensure proper flow of urine.Review of R4's Progress Note, dated 04/18/2025 at 12:48 PM and located under the Progress Notes tab of the EMR, revealed R4 had been hospitalized from [DATE] through 4/15/2025 for a urinary tract infection.Review of R4's significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/14/2025 and located under the MDS tab of the EMR, revealed R4 was unable to complete the Brief Interview for Mental Status (BIMS), had long and short-term memory problems, and was severely impaired in cognitive skills for daily decision making. It was recorded that the resident had an indwelling urinary catheter and was dependent on staff for most activities of daily living (ADLs).During an observation on 7/28/2025 at 9:14 am, R4 was observed lying in bed. Her urinary catheter drainage bag was observed lying on the floor, and the tubing was touching the floor.During an observation on 7/31/2025 at 10:50 am, R4 was observed in the common area in front of the nurses' station. Her urinary catheter drainage bag was attached to her geriatric chair, and the drainage bag and tubing were lying on the floor.During an observation and interview on 7/31/2025 at 10:53 am, Certified Nurse Aide (CNA) 1 was asked if the resident was prone to urinary tract infections. She stated yes. CNA1 was asked where the urinary catheter bag should be placed when the resident was up in her chair. She stated it should be hooked on the back of the chair so that the bag and tubing did not touch the floor. CNA1 was asked to confirm the location of R4's urinary drainage bag and tubing. She observed and stated that both the tubing and the drainage bag were on the floor and should not be. During an interview on 7/31/2025 at 10:59 am, the Assistant Director of Nursing (ADON) stated urinary catheter bags and tubing should not be on the floor, as this was an infection control concern.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, and record review, the facility failed to ensure communication with the dialysis center, failed to monitor the dialysis access site, and failed to have documented blood pressures and weights, as ordered by the physician, for one of one resident (R) (R9) reviewed for dialysis out of a total sample of 22. These deficient practices had the potential to place R9 at increased risk of complications related to dialysis. Findings include:Review of R9's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R9 was admitted to the facility on [DATE] with diagnoses that included end-stage renal disease and dependence on renal dialysis.Review of R9's Physician Orders, located under the Orders tab of the EMR, revealed the following orders:3/3/2023 - weigh on non-dialysis days every Tuesday, Thursday, Saturday, and Sunday5/23/2023 - take blood pressure every day shift2/8/2024 - assess right permacath (dialysis access site) site every shift for signs and symptoms of infection.Review of R9's Care Plan, dated 7/16/2024 and located under the Care Plan tab of the EMR, revealed a focus related to end-stage renal disease. The goal was that R9's dialysis care would be coordinated between the facility and the dialysis center through the review date. Interventions included communicating with the dialysis center on an ongoing basis and monitoring and assessing the site for signs and symptoms of infection, bleeding, or pain.Review of R9's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/3/2025 and located under the MDS tab of the EMR, revealed R9 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. It was documented that the resident received dialysis services.a. Review of R9's Refusal of Treatment, dated 8/20/2024 and located under the Misc (Miscellaneous) tab of the EMR, revealed, . I, [R9], am exercising my right to refuse treatment. The staff has explained to me the long and short term consequences of this refusal as listed below and I fully understand these consequences. The facility has tried to offer alternative treatments which I have also refused. I hereby release this facility of any responsibility for anything that may occur due to my refusal . Treatment resident refuses: fluid restriction . short and long term consequences of refusal: fluid overload, death .Review of R9's Medication Administration Records (MARs), located under the Orders tab of the EMR, and Progress Notes and Vital Signs tabs of the EMR revealed the following:5/2025 - weight not obtained on non-dialysis days for nine of 18 opportunities; dialysis access site not assessed on day shift on 12 of 31 opportunities, and blood pressure not monitored on the day shift on 11 of 31 opportunities.6/2025 - weight not obtained on non-dialysis days for eight of 17 opportunities; dialysis access site not assessed on day shift on 11 of 30 opportunities, and blood pressure not monitored on the day shift on 10 out of 30 opportunities.7/2025 - weight not obtained on non-dialysis days for two of 17 opportunities; dialysis access site not assessed on day shift on three of 29 opportunities, and blood pressure not monitored on day shift on three of 29 opportunities.b. Review of R9's Progress Notes, Misc (Miscellaneous), and Assessments tab of the EMR, dated 1/2025 through 7/28/25, revealed no documented evidence of any communication between the facility and the resident's dialysis center. During an observation and interview on 7/28/2025 at 3:08 pm, R9's dialysis access site was observed with a dressing intact, and no signs or symptoms of infection or bleeding were noted. R9 stated she did not take any type of written communication with her when she went to dialysis and that she did not bring anything back from the dialysis center. R9 stated she did not think the facility took her blood pressure every day, but she could not be sure. R9 stated she did not think she was weighed every day.During an interview on 7/30/2025 at 2:09 pm, Licensed Practical Nurse (LPN) 2, who was assigned to R9, was asked how the facility communicated with R9's dialysis center. She stated, They call us with problems and we call them with problems. LPN2 was asked if any communication documentation was used between them and the dialysis center. LPN2 stated, No. LPN2 stated the facility obtained its own vital signs, including weights on non-dialysis days. LPN2 stated the mechanical lift had a built-in scale that was used to obtain the resident's weight. LPN2 stated she did not do anything with the resident's dialysis access site. She was asked if she monitored the site for signs and symptoms of infection. LPN2 stated, Our wound nurse would do that.During an interview on 7/30/2025 at 2:23 pm, LPN2 was asked about the missing vital signs and weights that had been identified on R9's MARs for 5/2025 through 7/2025. She stated it was improper documentation. She stated she had been documenting incorrectly and had been clicking a button in the EMR, which caused a 9 to appear in areas without documented blood pressures and weights. LPN2 was asked how the facility would

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, review of manufacturer's guidelines, and review of facility policies titled Insulin Administration, and Administering Medications through a Handheld Nebulizer, the facility failed to ensure a medication error rate of less than five percent for four of 13 residents (R) (R64, R48, R7, and R16) observed during the medication pass out of a total sample of 22 residents. There were four errors out of 34 opportunities, resulting in a medication error rate of 11.76 percent. These failures had the potential to place R64, R48, R7, and R16 at risk of not receiving the prescribed dosage of medication. Findings include:Review of the facility's policy titled Insulin Administration, dated 09/2014, revealed no documentation related to priming insulin pens.Review of the facility's undated policy titled Administering Medications through a Handheld Nebulizer, revealed no documentation related to the fit of a nebulizer mask. Review of the manufacturer's Flex Pen package insert, dated 4/2025, revealed, . Check the insulin flow . Turn the dose selector to 2 units . Hold your FlexPen with the needle pointing upwards . Press the push-button until the dose shows 0 and lines up with the pointer . If you do not check the insulin flow, you may not receive your full insulin dose . Review of the manufacturer's KwikPen Instructions for Use package insert, dated 7/2023, revealed, . Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin . To prime your Pen, turn the Dose Knob to select 2 units . Hold your Pen with the Needle pointing up . Push the Dose Knob in until it stops, and 0 is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly . You should see insulin at the tip of the Needle . Review of the manufacturer's Fiasp FlexTouch package insert, dated 6/2023, revealed, . Turn the dose selector to select 2 units . Hold the Pen with the needle pointing up . Press and hold in the dose button until the dose counter shows 0 . A drop of insulin should be seen at the needle tip .1. Review of R64's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R64 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus.Review of R64's Physician Order, dated 12/3/2024 and located under the Orders tab of the EMR, revealed R64 was to receive Fiasp Insulin Aspart with Niacinamide Injection Solution 100 units/milliliter (ml) subcutaneously every two hours, based on a sliding scale. For a blood sugar level of 251 to 360, it was ordered for R64 to receive five units of Fiasp. During an observation on 7/29/2025 at 11:25 am, Licensed Practical Nurse (LPN) 3 was observed obtaining a reading from R64's glucose monitoring system. The reading revealed that R64's blood sugar level was 290. LPN3 obtained R64's Fiasp Flex Touch pen from the medication cart, turned the dial to five units, and administered the medication. LPN3 did not prime the insulin pen as per the manufacturer's instructions.2. Review of R48's admission Record, located under the Profile tab of the EMR, revealed R48 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus.Review of R48's Physician Order, dated 6/12/2025 and located under the Orders tab of the EMR, revealed R48 was to receive Novolog Injection Solution 100 units/ml subcutaneously before meals and at bedtime, based on a sliding scale. For a blood sugar level of 243, it was ordered for R48 to receive four units of Novolog insulin.During an observation on 7/29/2025 at 11:31 am, LPN3 was observed obtaining a fingerstick blood sugar level (FSBS) for R48. The reading was 243. LPN3 obtained R48's Novo Nordik insulin pen from the medication cart, turned the dial to four units, and administered the medication. LPN3 did not prime the insulin pen as per the manufacturer's instructions.3. Review of R7's admission Record, located under the Profile tab of the EMR, revealed R7 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus. Review of R7's Physician Order, dated 1/6/2025 and located under the Orders tab of the EMR, revealed R7 was to receive Admelog Injection Solution (Insulin Lispro) 100 unit/ml subcutaneously before meals and at bedtime, based on a sliding scale. For a blood sugar level of 199, it was ordered for R7 to receive one unit of Lispro insulin.During an observation and interview on 7/29/2025 at 11:59 am, LPN3 was observed obtaining a FSBS reading for R7. The reading was 199. LPN3 obtained R8's Insulin Lispro Kwik Pen from the medication cart, turned the dial to one unit, and began to administer the medication. The surveyor stopped LPN3 and asked if she had primed the insulin pen before beginning the administration. LPN3 stated, No. LPN3 primed the Kwik Pen and then administered one unit of Lispro to R7.During an interview on 7/29/2025 at 12:05 pm, LPN3 confirmed she had not primed the insulin pens for R64 or R48. LPN3 stated she was unaware that insulin pens should be primed before each use During an interview on 7/30/2025 at 10:00 am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115406	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wrightsville Manor Health and Rehab	337 West Court Street Wrightsville, GA 31096

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews and record review, the facility failed to document an episode of hypoglycemia (low blood sugar) for one of five residents (R) (R8) reviewed for unnecessary medications out of a total sample of 22. This deficient practice had the potential to place R8 at increased risk for medical complications. Findings include: Review of R8's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R8 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus.Review of R8's Physician Order, dated 6/13/2025 and located under the Orders tab of the EMR, revealed R8 was to have fingerstick blood sugar (FSBS) checks before meals and at bedtime. It was recorded that the physician was to be notified if R8's blood sugar level was below 80 or greater than 400. Review of R8's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/25/2025 and located under the MDS tab of the EMR, revealed R8 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. During an interview on 7/30/2025 at 12:13 pm, R8 stated, My blood sugar dropped on the preceding day (7/29/2025). R8 stated that when the episode happened, her roommate got Licensed Practical Nurse (LPN) 3. R8 stated LPN3 checked her blood sugar level, and it was 61. R8 stated LPN3 brought her orange juice and sugar, and when LPN3 rechecked her blood sugar, it was 91. R8 stated that three nurses were involved in helping her with her blood sugar level. Review of R8's entire EMR revealed no documented evidence of the incident with R8's blood sugar on 7/29/2025. On 7/30/2025 at 4:37 pm, the Assistant Director of Nursing (ADON) was asked if anything had been reported to her regarding R8's blood sugar being low on 7/29/2025. She stated, No. The ADON called LPN3, and the surveyor spoke to LPN3 in the presence of the ADON. LPN3 was asked if there had been an incident with R8's blood sugar dropping on 7/29/2025. LPN3 stated, Yes. LPN3 stated R8 reported that her blood sugar was low, so she checked it, and it was 60. LPN3 stated she gave the resident orange juice. LPN3 was asked if she documented the incident. She stated, No. During an interview on 7/30/2025 at 4:39 pm, the ADON stated the expectation was for these types of episodes to be documented. During an interview on 7/31/2025 at 2:00 pm, the Administration stated it was her expectation that nurses perform their duties according to current standards of practice.

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	115406	A. Building B. Wing	07/31/2025

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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 - Some	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115406	A. Building B. Wing	07/31/2025

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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 - Some	Based on observation, interview, and record review, the facility failed to administer medications in a manner to prevent cross-contamination for seven of 13 residents (R) (R62, R65, R56, R30, R33, R22, and R45) observed receiving medications. This deficient practice had the potential to place R62, R65, R56, R30, R33, R22, and R45 at risk of avoidable infections. Findings include:1. During continuous observations of the medication pass on 7/29/2025 and beginning at 1:10 pm, the following was observed:1. 1:10 pm: Licensed Practical Nurse (LPN) 2 was observed preparing a medication for R62. LPN2 opened the medication cart, obtained a medication card, popped a pill into a medication cup, placed the medication card back into the cart, and then locked the cart. LPN2 poured water into a cup and then went outside to the smoking area where R62 was located and administered the medication. R62 drank the water and handed the cup back to LPN2 for disposal. LPN2 then re-entered the building. LPN2 touched the door handle going outside and coming back inside.2. 1:15 pm: LPN2 approached the medication cart, and without performing hand hygiene, LPN2 opened the medication cart, prepared three oral medications for R65, and closed the cart. LPN2 poured water into a cup and then went outside to the smoking area where R65 was located and administered the medication. R65 drank the water and handed the cup back to LPN2 for disposal. LPN2 then re-entered the building. LPN2 touched the door handle going outside and coming back inside.3. 1:20 pm: LPN2 approached the medication cart, and without performing hand hygiene, LPN2 opened the medication cart, prepared three oral medications for R56, and closed the cart. LPN2 poured water into a cup and then administered the medications to R56 in his room. R56 drank the water and handed the cup back to LPN2 for disposal.4. 1:28 pm: LPN2 approached the medication cart, and without performing hand hygiene, LPN2 opened the medication cart, prepared two oral medications for R30, and closed the cart. LPN2 poured water into a cup and then went to R30 in the hallway and administered the medications. R30 drank the water and handed the cup back to LPN2 for disposal.5. 1:36 pm: LPN2 approached the medication cart, and without performing hand hygiene, obtained a respiratory inhaler from the cart for R33. R33 came to the medication cart, LPN2 handed the inhaler to R33, and R33 self-administered the medication and gave the inhaler back to LPN2. LPN2 placed the inhaler back into the medication cart.6. 1:40 pm: LPN2 prepared one oral medication for R22 and poured a cup of water. LPN2 approached R22, administered the medication, and returned to the medication cart.7. 1:42 pm: LPN2 did not perform hand hygiene, opened the medication cart, prepared one oral medication, and obtained a bottle of eye drops for R45. LPN2 closed the drawer, performed hand hygiene with hand sanitizer, and gathered a tissue and an empty cup. LPN2 stated she always completed hand hygiene before a treatment, and the eye drops were considered a treatment. LPN2 was asked if she performed hand hygiene at any other time during a medication pass. She stated she washed her hands with soap and water at the beginning of a medication pass, but unless she was completing a treatment, she did not perform hand hygiene between medication administrations. LPN2 was asked if she had touched the door handle when leaving and entering the building when she had gone outside to administer medications. She stated, Yes. LPN2 was asked if she had touched anything in the residents' environments during the medication pass. She stated, Yes. LPN2 was asked if she had touched objects that had been touched by the residents and/or other staff members. She stated, Yes. LPN2 was asked if the potential for cross-contamination was present during the medication pass. She stated, Yes.During an interview on 7/31/2025 at 10:19 am, the Assistant Director of Nursing (ADON) stated staff were expected to wash their hands before starting the medications pass and that hand hygiene should be performed between residents. She stated that, if needed due to soilage during the medication pass, staff should wash their hands again. The ADON was asked to provide the facility's hand-washing policy. She stated the facility did not have a specific handwashing policy, but a skills check was completed for all staff members related to handwashing.On 7/31/2025 at 10:40 am, the ADON provided an undated Handwashing Skills Check for LPN2. It was recorded that LPN2 had performed hand washing competently. At the bottom of the form, it was recorded, . Nurses: Hand hygiene between each resident med pass .