STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115536	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winder Center for Nursing and Healing	263 E May Street Winder, GA 30680

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interviews, record review, and a review of the facility policies titled Transfer and Discharge [including Against Medical Advice (AMA)] and Bed Hold Prior to Transfer, the facility failed to provide residents and their Resident Representatives (RR) with the required written transfer and bed-hold notices following emergent hospital transfers for four of four sampled residents (R) (R93, R10, R155, and R34). This failure limited residents' and representatives' ability to understand appeal rights and access Ombudsman information, placing all residents at risk for potential denial of readmission and loss of their residence after hospitalization.Findings included:A review of the facility's policy titled Transfer and Discharge [including Against Medical Advice (AMA)], dated March 2025, revealed that the facility's transfer/discharge notice will be provided to the resident and resident representative; the notice will include all of the following at the time it is provided: A. The specific reason and basis for transfer or discharge. B. The effective date of transfer or discharge. C. The specific location.to which the resident is to be transferred or discharged . D. An explanation of the right to appeal the transfer or discharge to the State. E. The name, address [mailing and email], and telephone number of the State entity that receives such appeal hearing requests. F. The information on how to obtain an appeal form. G. Information on obtaining assistance in completing and submitting the appeal hearing request. H. The name, address [mailing and email], and phone number of the representative of the Office of the State Long-Term Care Ombudsman. A review of the facility's policy titled Bed Hold Prior to Transfer, dated March 2025, revealed that it is the policy of the facility to provide written information to the resident and /or resident representative regarding bed hold practices . at the time of a transfer for hospitalization. In the event of an emergency transfer of a resident, the facility will provide written notice of the facility's bed-hold policies to the resident and/or resident representative within 24 hours. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file and/or medical record. 1. A review of R93's electronic medical record (EMR) revealed an admission date of 9/9/2025 and a readmission date of 1/16/2026 with diagnoses of paraplegia (paralysis to the lower half of the body) and an unstageable pressure ulcer. A review of R93's EMR quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/16/2025 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that R93's cognition was intact. A review of R93's EMR Progress Notes dated 1/2/2026 at 12:56 pm indicated, Change of condition . Send to ER [Emergency Room] . A review of R93's EMR Progress Notes dated 1/4/2026 at 6:44 pm indicated, . readmitted from . (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	hospital . A review of R93's EMR Progress Notes dated 1/9/2026 at 3:22 pm indicated, . Primary Care Provider responded with . Send to ER for antibiotic therapy . A review of R93's EMR Progress Notes dated 1/16/2026 at 3:04 pm indicated, Resident arrived [from hospital] . 2. A review of R10's EMR Face Sheet revealed an admission date of 9/4/2025 with a diagnosis of metabolic encephalopathy. A review of R10's quarterly MDS with an ARD of 1/14/2026 revealed a BIMS score of 14 out of 15, which indicated that R10's cognition was intact. A review of R10's EMR Progress Notes dated 10/5/2025 at 2:53 pm indicated, . Resident observed by med [medication] tech [technician] with unresponsive and seizure-like activity. Med tech reported to writer that resident was unresponsive . 911 called . patient sent out to . hospital for further evaluation . A review of R10's EMR Progress Notes dated 10/8/2025 at 4:04 pm indicated, . Patient returned . A review of R10's EMR Progress Notes dated 11/14/2025 at 1:19 pm indicated, . Patient labs abnormal . NP [Nurse Practitioner] to send out for evaluation. 911 notified, EMTs [emergency medical technicians] arrived . transported patient to . hospital . A review of R10's EMR Progress Notes dated 11/18/2025 at 4:30 pm indicated, . Patient returned from hospital . A review of R10's EMR Progress Notes dated 12/19/2025 at 6:52 am indicated, . Resident sent to [hospital] ER per on-call NP order . A review of R10's EMR Progress Notes dated 12/24/2025 at 3:34 pm indicated, . Patient arrived VIA stretcher . 3. A review of R155's EMR Face Sheet revealed an admission date of 12/15/2025 with a diagnosis of hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness) following cerebral infarction (stroke) affecting the left side. A review of R155's admission MDS with an ARD of 12/21/2025 revealed a BIMS score of 11 out of 15, which indicated R155 was moderately impaired A review of R155's Progress Notes dated 12/28/2025 at 8:28 am indicated, . NP notified this morning due to ongoing respiratory distress and increased oxygen requirement, NP ordered transfer to ER for further evaluation . 4. A review of R34's admission Record revealed an original admission date of 2/6/2019 with diagnoses of spastic hemiplegia affecting the left nondominant side, dysphagia (difficulty swallowing), and pressure ulcer. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of R34's Progress Notes revealed notes dated 8/24/2025, indicating R34 was transferred to the hospital for seizure, and 10/25/2025, indicating R34 was transferred to the hospital for elevated heart rate and temperature. A review of R93's, R10's, R155's, and R34's EMR's Progress Notes revealed no documentation that the transfer notices and bed hold notices were provided to the residents or their resident representatives. During an interview on 1/21/2026 at 2:55 pm, the Business Office Manager (BOM) confirmed that the facility did not provide a transfer notice or a bed hold notice to residents and RRs when a resident is transferred out to the hospital.

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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, interviews, and a review of the facility policy titled Sanitation, the facility failed to ensure kitchen staff thoroughly cleaned and air-dried pots, pans, and foodˆservice equipment before storage. This failure increased the potential risk of foodborne illness and had the potential to affect 143 of the 146 residents receiving dietary services.Findings included:A review of the facility policy titled Sanitation, dated April 2024, revealed that the food service area shall be maintained in a clean and sanitary manner. All utensils, counters, shelves, and equipment shall be kept clean and maintained in good repair. All equipment, utensils, and food contact surfaces shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. Food preparation equipment and utensils that are washed and sanitized will be allowed to air dry.During an observation and interview on 1/19/2026 at 9:40 am, the Dietary Manager (DM) confirmed six pans, 6 inches by 12 inches by 4 inches; three pans 10 inches by 12 inches by 4 inches; three pans 6 inches by 10 inches by 4 inches; and one pan 18 inches by 24 inches by 1 inch, cleaned and stacked for use, were still wet with some having food residue remaining on them. The pans had been stacked while still wet and were not given adequate time to air-dry. The DM acknowledged this and stated, They should be dry. I'm going to re-wash them; they were not properly dried before stacking. They should not have food residue on them; it increases the risk of contamination. Additionally, the can opener blade was observed to have food residue.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations, interviews, and a review of the facility's policy titled Food-Related Garbage & Rubbish Removal, the facility failed to ensure proper disposal and containment of waste in two of the two dumpsters. This failure had the potential to affect all 146 residents, as well as visitors and staff, and increased the risk of attracting pests.Findings included:A review of the facility's policy titled Food-Related Garbage & Rubbish Removal, dated April 2024, revealed that food-related garbage and rubbish shall be disposed of in accordance with current local and state laws regulating such matters. All garbage and rubbish containing food waste shall be kept in containers. Garbage and rubbish containing food waste will be stored in a manner that is inaccessible to vermin. Outside dumpsters provided by garbage pick up services will be kept closed, have a drain plug in place, and be free of surrounding litter.During an observation and interview on 1/19/2026 at 10:00 am with the Dietary Manager (DM) of the enclosed area in the parking lot behind the building, where the trash dumpsters were located revealed that the top lids of the two dumpsters used to contain the facility's trash were open. The DM stated, The dumpsters are supposed to be closed. Other staff use them also; I'm not sure why this falls on the kitchen.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on document review, interviews, and a review of the facility's policy titled Antibiotic Stewardship Program, the facility failed to ensure antibiotics were prescribed only when a diagnosed infection was present for eight of 12 months of antibiotic stewardship reviewed. This failure had the potential to affect all residents in the facility and to increase the risk of adverse events, including the development of antibiotic-resistant organisms, due to unnecessary or inappropriate antibiotic use.Findings included:A review of the facility's policy titled Antibiotic Stewardship Program, dated October 2025, indicated, It is the policy of this facility to implement an Antibiotic Stewardship Program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. Policy Explanation and Compliance Guidelines. 4. The program included antibiotic use protocols and a system to monitor antibiotic use. a. Antibiotic use protocols . ii. Laboratory testing shall be in accordance with current standards of practice. Iv. The McGeer's Criteria are used to determine whether to treat an infection with antibiotics. b. Monitoring antibiotic use: v. at least one outcome measure associated with antibiotic use will be tracked monthly as prioritized from the facility's infection control risk assessment and other infection surveillance data . 5. At least annually, feedback shall be provided on the facility's antibiotic use data in the form of a written report share with administration, medical and nursing staff . and QAA Committee.6. At least annually, the Medical Director shall be provided feedback on antibiotic use data in the facility. 7. Education regarding antibiotic stewardship shall be provided at least annually to facility staff, prescribing practitioners, residents, and families. 9. Documentation related to the program is maintained by the Infection Preventionist, including . b. Assessment forms . c. Antibiotic use protocol/algorithms. d. Data collection forms for antibiotic use, process, and outcome measures . g. Records related to education of physicians, staff, residents, and families . A review of the Antibiotic Stewardship Program binder provided by the Infection Preventionist (IP) for January 2025 through August 2025 revealed a document titled Monthly Infection Line Listing which indicated the categories: resident's name, symptoms concerns, body site of infection, culture/x-ray results, antibiotic ordered, start date of antibiotic use, surveillance criteria McGeer met, Healthcare associated Infection (HAI) or community acquired infection, antimicrobial stewardship form completed, resolved, and reportable disease.A review of January 2025's Monthly Infection Line Listing revealed that 16 of the 39 residents identified as receiving an antibiotic had no documentation of a culture/x-ray result. In addition, even though the column for surveillance criteria McGeer met was marked either yes, no, or non-applicable (n/a), there was no documentation to support how the decision was made to mark the criteria as either yes, no, or n/a. Of the 39 residents listed on the document, there was no documentation on whether the infection was HAI or community-acquired, if it resolved, or if the antimicrobial stewardship form was completed.A review of the February 2025 Monthly Infection Line Listing revealed that 11 of the 38 residents identified as receiving an antibiotic had no documentation of a culture/x-ray result. For four additional residents who received an antibiotic, the culture/x-ray column was marked as no culture/x-ray completed because they received hospice care. In addition, even though the column for surveillance criteria McGeer met was marked either yes, no, or n/a, there was no documentation to support how the decision was made to mark the criteria as either yes, no, or n/a. Of the 38 residents listed on the document, there was no documentation on whether the infection was HAI or community-acquired, if it resolved, or if the antimicrobial stewardship form was completed.A review of the March 2025 Monthly Infection Line Listing indicated that 31 of 44 residents identified as receiving an antibiotic had no documentation of a culture/x-ray result. In addition, even though the column for surveillance criteria McGeer met was marked either yes, no, or n/a, for the 44 residents, there was no documentation to support how the decision was made to mark the criteria as either yes, no, or n/a. The document indicated that for 31 of 44 residents who received an antibiotic, the column for whether the infection met McGeer's criteria was marked as n/a or no. There was no (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	documentation on how this decision was determined. Of the 44 residents listed on the document, seven of the 44 were marked as having a HAI, while the other 37 residents' columns lacked any information on whether the infection was HAI or community-acquired. The columns for resolved and antimicrobial stewardship form completed were left blank.A review of the April 2025 Monthly Infection Line Listing indicated that 28 of the 44 residents identified as receiving an antibiotic had no documentation of a culture/x-ray result. In addition, even though the column for surveillance criteria McGeer met was marked either yes, no, or n/a, there was no documentation to support how the decision was made to mark the criteria as either yes, no, or n/a. The line listing document did not indicate for any of the 44 residents listed whether the infection was HAI or community-acquired, whether it resolved, or whether the antimicrobial stewardship form was completed.A review of the May 2025 Monthly Infection Line Listing indicated that 24 of the 41 residents identified as receiving an antibiotic had no documentation of a culture/x-ray result. One of the 24 residents with no documentation of a culture/x-ray indicated the reason was that the resident was in hospice. Even though the column for surveillance criteria McGeer met was marked either yes, no, or n/a, there was no documentation to support how the decision was made to mark the criteria as either yes, no, or n/a. In addition, the April line listing document did not indicate for any of the 41 residents listed whether the infection was HAI or community-acquired, if it resolved, or if the antimicrobial stewardship form was completed.A review of the June 2025 Monthly Infection Line Listing indicated that 28 of the 37 residents identified as receiving an antibiotic had no documentation of a culture/x-ray result. Two of the 28 residents with no documentation of a culture/x-ray indicated the reason was that the residents were in hospice. In addition, even though the column for surveillance criteria McGeer met was marked either yes, no, or n/a, there was no documentation to support how the decision was made to mark the criteria as either yes, no, or n/a. The line listing document did not indicate for any of the 41 residents listed whether the infection was resolved or if the antimicrobial stewardship form was completed.A review of July and August 2025 revealed that the Monthly Infection Line Listing was not used; instead, there was a document titled Order listing report, which indicated the residents' names, the antibiotic ordered, the date of the order, and whether the antibiotic was discontinued or completed. For some residents in this report, the antibiotic continued without any rationale.A review of the January through August 2025 Antibiotic Stewardship documentation revealed that types of infections were identified each month. However, there was no documentation that the IP conducted in-service education of facility nursing staff, discussed the types and number of infections, and provided the Medical Director or providers with a report of antibiotic usage. In addition, there was no documentation on whether education was provided to the providers when it was determined that infections did not meet McGeer's criteria for the use of an antibiotic.During an interview on 1/22/2026 at 3:03 pm, the Director of Nursing (DON) and the IP were informed that the Antibiotic Stewardship documentation for January 2025 through August 2025 lacked documentation of how it was determined whether the infection and use of the antibiotic met or did not meet McGeer's criteria. In addition, they were informed that for July and August 2025, the Antibiotic Stewardship monthly line listing was not completed. The DON and IP were asked whether there was additional information that could be provided for these months, and, based on the categories of infections identified for these months, was there any education of providers or nursing staff. The facility's Antibiotic Stewardship policy was reviewed with the DON and IP, and they were asked if there was any annual report provided to the Medical Director, providers, nursing staff, and residents regarding antibiotic usage. The DON stated that she was the facility's wound nurse during this time period and that the facility had a different IP for these months. The DON stated that she would look for additional information.During an interview on 1/22/2026 at 3:53 pm, the DON confirmed that there was no additional information to provide and that there was no documentation of annual reports being shared with administration, medical, and nursing staff, and residents/families. The DON confirmed that there was no evidence of a report shared with the Medical Director or providers regarding antibiotic usage, and no documentation, based (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	on the categories of infections identified for each month, was provided to providers, nursing staff, or residents.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and a review of the facility policy titled Resident Assessment-Coordination with PASRR Program, the facility failed to complete a Level II pre-admission screening and resident review (PASARR) evaluation after a resident received a post-admission mental illness diagnosis for one of 32 sampled residents (R) (R41). This deficient practice could lead to residents not receiving necessary services.Findings included:A review of the facility policy titled Resident Assessment- Coordination with PASRR Program, revised Decemebr 2024, revealed that the facility coordinates assessments with the preadmission screening and resident review [PASARR] program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. An example included: A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR.A review of R41's admission Record located in the electronic medical record (EMR) revealed an original admission date of 8/13/2014 with diagnoses of hypertensive heart disease and chronic kidney disease with heart failure, hypertension, and alcoholic cirrhosis of the liver without ascites.A review of R41's PASRR Level 1 Assessment provided by the facility staff revealed a Level I assessment dated [DATE] with no mental illness diagnosis and no Level II PASSAR completed.A review of R41's EMR's Psychiatric Diagnostic Evaluation dated 6/19/2018, revealed a diagnosis of post-traumatic stress disorder (PTSD).Further review of the EMR and facility documents revealed no additional PASARR was completed after the diagnosis of PTSD.During an interview on 1/21/2026 at 4:15 pm, the Social Service Director (SSD) was asked about the PASARR Level II after the new diagnosis of PTSD. The SSD said that he needed to look into the issue.During an interview on 1/22/2026 at 8:45 am, the SSD stated that there had not been any additional PASARRs completed after the diagnosis in 2018. The SSD confirmed that a Level II should have been completed after the diagnosis.During an interview on 1/22/2026 at 10:35 am, the Administrator was asked what the expectation was when an existing resident received a diagnosis of mental illness. The Administrator stated the expectation was that a Level II PASARR would be completed.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, interviews, record review, and review of the facility's policy titled Food Preparation and Service, the facility failed to ensure residents were served food that was palatable to four of 32 sampled residents (R) (R131, R93, R160, and R48). Findings included:A review of the undated facility policy titled Food Preparation and Service revealed that food service employees shall prepare and serve food in a manner that complies with safe food handling practices. The Cooking and Holding Temperatures and Times section noted that the danger zone for food temperatures is between 41 degrees and 135 degrees, and that this temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illnesses. The facility policy failed to address specific temperatures for food being served other than actual cooking temperatures. 1. A review of R131's electronic medical record (EMR) Face Sheet indicated an admission date of 1/26/2023 and a readmission date of 3/12/2025. A review of R131's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/8/2026 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that R131's cognition was intact. During an interview on 1/19/2026 at 10:02 am, R131 stated that the food at his meals tasted cold. 2. A review of R93's EMR Face Sheet revealed an admission date of 9/9/2025 and a readmission date of 1/16/2026. A review of R93's quarterly MDS with an ARD of 12/16/2025 in the EMR revealed a BIMS score of 15 out of 15, which indicated that R93's cognition was intact. During an interview on 1/19/2026 at 2:55 pm, R93 stated that the food was overseasoned, and the vegetables were overcooked. 3. A review of R160's EMR Face Sheet indicated an admission date of 1/14/2026. A review of R160's admission MDS with an ARD of 1/15/2026 indicated a BIMS score of 12 out of 15, which indicated R160's cognition was moderately impaired. During the group meeting on 1/20/2026 at 11:30 am, R160 stated that he had only been a resident of the facility since last Thursday and that the meal delivery had caused the food on his tray to taste cold. R160 stated that the carts, once they arrived on the unit, were not served by nursing staff until much later, which caused the food to taste cold. 4. A review of R48's EMR Face Sheet indicated an admission date of 5/2/2025. A review of R48's quarterly MDS with an ARD of 11/6/2025 indicated a BIMS score of 15 out of 15, which indicated R48 was cognitively intact. During the group meeting on 1/20/2026 at 11:30 am, R48 agreed that the food served on her meal tray was served cold to her in her room. 5. During an observation on 1/21/2026 at 12:03 pm, the temperatures of the lunch items on the steam (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	table being served were taken by the Registered Dietitian (RD). The RD used the facility's digital thermometer for the readings. The temperatures taken during the observation, and confirmed by the RD, were as follows: Lasagna measured 186 degrees Fahrenheit (F) for regular texture. Lasagna measured 162 degrees F for puree texture. Peas measured 198 degrees F for regular texture. Peas measured 190 degrees F for puree texture. During an observation on 1/21/2026 at 2:02 pm, the requested test tray was plated and placed on the cart for delivery to the 600 hallway. The food cart was followed to the 600 hallway along with the Dietary Manager (DM). The last resident was served at 2:16 pm, and the test tray was removed from the meal cart by the DM and taken to a nearby counter. The DM proceeded to take the food temperatures utilizing the facility's thermometer; the results were confirmed by the DM as follows: Lasagna measured 115 degrees F for regular texture. Lasagna measured 99 degrees F for puree texture. Peas measured 101 degrees F for puree texture. Immediately preceding the temperature observation, the DM then tasted the food served on the requested test tray and revealed, The taste and texture of the food is okay, but the temperature is cool, and it would probably taste better if it were warmer. During an interview on 1/22/2026 at 10:35 am, the Administrator stated, It is my expectation that food served to the residents would be at the appropriate temperature for the specific item.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115536	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winder Center for Nursing and Healing	263 E May Street Winder, GA 30680

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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	Provide and implement an infection prevention and control program. Based on observations, interviews, record review, and a review of the facility's policy titled Handwashing/Hand Hygiene, the facility failed to ensure hand hygiene was performed following the administration of inhaled medication for one of six residents (R) (R53) observed during medication administration. The failure to perform proper hand hygiene created a risk for bacterial contamination of medication cart supplies and increased the potential for infection transmission.Findings included:A review of the facility's undated policy titled Handwashing/Hand Hygiene revealed that the facility considers hand hygiene the primary means to prevent the spread of infections. Use an alcohol-based hand rub containing at least 62% alcohol; alternatively, soap [antimicrobial or non-antimicrobial] and water for the following situations: Before and after direct contact with residents.A review of R53's electronic medical record (EMR) Face Sheet revealed an admission date of 2/11/2025. R53 had diagnoses including chronic obstructive pulmonary disease (COPD).A review of R53's Orders tab of the EMR revealed a current order for Advair 250/50 diskus (an inhaled combination of steroid and bronchodilator to reduce inflammation and open airways) twice daily.During an observation on 1/21/2026 at 8:10 am, Certified Medication Assistant (CMA) sanitized her hands and set up medications, including the Advair Diskus. The CMA removed the diskus from its box and used an ungloved hand to manually slide open the cover over the mouthpiece and load a dose before she handed the diskus to R53. R53 put her mouth over the mouthpiece, inhaled the medicated powder, and handed the diskus back to CMA. CMA closed the opening with her ungloved hand and placed the Advair Diskus back in its box. CMA then went to the medication cart and put the medication box back in the cart. Without performing hand hygiene, CMA used the computer on the cart by moving the mouse with her hand, then opened drawers on the cart and touched multiple bottles and boxes of medications before she sanitized her hands.During an interview on 1/21/2026 at 8:24 am, CMA stated, I do usually use gloves to give Advair. CMA added, I wash my hands after meds [medications]. Now I am going to go wash my hands. CMA headed to the bathroom sink.During an interview on 1/22/2026 at 12:45 pm, the Administrator acknowledged infection control risk associated with lapses in handwashing.During an interview on 01/22/26 at 12:51 pm, the Director of Operations (DOO) reported, Handwashing should be standard practice.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and a review of the facility's policy titled Pneumococcal Vaccine (Series), the facility failed to ensure that one of five residents (R) (R41) was offered and administered pneumococcal vaccinations in accordance with nationally recognized standards. Specifically, the facility failed to offer or administer the appropriate pneumococcal vaccine to R41, who was eligible to receive either Prevnar 20 (PCV20) or PCV15 one year after receiving Pneumovax 23 (PPSV23). Additionally, the facility failed to obtain a complete vaccination history, provide education regarding the pneumococcal vaccine, and secure a signed consent indicating refusal of the vaccine for a resident (R58). These failures had the potential to increase residents' risk of contracting pneumonia.Findings included:A review of the facility's policy titled, Pneumococcal Vaccine (Series), dated April 2022, indicated, Policy: It is the policy to offer our residents . immunization against pneumococcal disease in accordance with current CDC [Centers for Disease Control] guidelines and recommendations. Policy Explanation and Compliance Guidelines . 1. Each resident will be assessed for pneumococcal immunization upon admission . 3. Prior to offering the pneumococcal immunization, each resident, or the resident' representative will receive education regarding the benefits and potential side effects of the immunization . 4. The resident/representative retains the right to refuse the immunization. A consent form shall be signed . and filed in the individual's medical record . 7b. For adults 65 years or older who have only received a PPSV23: Give one dose PCV15 or PCV20 at least one year after the most recent PPSVWE vaccination . 1. A review of R41's electronic medical record (EMR) Face Sheet indicated an admission date of 8/13/2014 and a readmission date of 3/7/2024. R41 was [AGE] years old.A review of R41's EMR Immunization revealed R41 received PPSV23 on 9/23/2020. There was no further documentation that R41 was offered or received PCV15 or PCV20 one year after receiving PPSV23 vaccination. The Immunization document in the EMR indicated that PCV13 was refused.During an interview on 1/21/2026 at 12:47 pm, the Infection Preventionist (IP) confirmed that there was no documentation that R41 was offered the PCV15 or PCV20 one year after receiving the PPSV23. The IP stated that even though the EMR Immunization document indicated that R41 refused the PCV13, the IP had no documentation, such as a signed consent form documenting the refusal.2. A review of R58's EMR Face Sheet indicated an admission date of 3/23/2023. R58 was [AGE] years old.A review of R58's EMR Immunization document revealed no documentation that any of the pneumococcal vaccines had been administered or refused. The IP provided documentation from R58's admission contract, Exhibit I, which indicated R58 refused the pneumococcal vaccine.During an interview on 1/21/2026 at 12:47 pm, the IP confirmed that there was no documented evidence that the facility followed the facility's policy to obtain R58's pneumococcal immunization information upon admission. The IP further stated that there was no documentation that R58 was provided education regarding the benefits and potential side effects of the immunization or that R58 signed a consent form that indicated R58 refused the pneumococcal vaccine.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review, interviews, and a review of the facility's policy titled COVID-19 Vaccination, the facility failed to ensure that one of five residents (R) (R58) reviewed for Coronavirus disease 2019 (COVID-19) immunization received education regarding the risks and benefits of the COVID-19 vaccine/booster before declining vaccination.Findings included:A review of the facility's policy titled, COVID-19 Vaccination, dated December 2025, indicated, It is the policy of this facility . by educating and offering our residents . the COVID-19 vaccine . Policy Explanation and Compliance Guidelines . 11. COVID-19 vaccination will be offered to residents . 14. The facility will educate and offer the COVID-19 vaccine to residents and maintain documentation of such . 21. The resident's medical record will include the documentation of the following: a. Education to the resident . regarding the risks, benefits, and potential side effects of the COVID-19 vaccine . c. If the resident did not receive the COVID-19 vaccine due to . refusal . A review of R58's EMR Face Sheet indicated an admission to the facility on 3/23/2023.A review of R58's EMR Immunization document under the Immunization tab revealed no documentation of whether any of the COVID-19 vaccines/boosters had been administered or refused. The Infection Preventionist (IP) provided documentation from R58's admission contract, Exhibit I, which indicated R58 refused the COVID-19 vaccine.During an interview on 1/21/2026 at 12:47 pm, the IP confirmed that there was no documentation that the facility followed the facility's policy that R58 was provided education regarding the benefits and potential side effects of the COVID-19 immunization or that R58 signed a declination/consent form that indicated R58 refused the COVID-19 vaccine.