

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115720	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2025
NAME OF PROVIDER OR SUPPLIER Evergreen Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 139 Moran Lake Road, NE Rome, GA 30161	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and review of the facility policy titled, Routine Cleaning and Disinfection, the facility failed to ensure a safe, clean, comfortable, homelike environment in the North and South hallways, resident rooms for four of 24 sampled residents (Resident (R)3, R4, R20, and R5), resident shower rooms, resident equipment for five of 24 sampled Rs (R22, R25, R24, R15, and R21), and the main dining room were maintained in a safe, clean, comfortable and clutter-free manner to create a homelike environment. Findings include: Review of the facility's policy titled Routine Cleaning and Disinfection dated 9/1/2022 states, Policy: It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. The policy in part provides Policy Explanation and Compliance Guidelines as follows: 1. Routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in common areas, resident rooms and at the time of discharge. 4. Routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high touch areas to include, but not limited to: a. Toilet flush handles. b. Bed rails. c. Tray tables. d. Call buttons. e. TV remotes. f. Telephones. g. Toilet seats. h. Monitor control panels, touch screens, and cables. i. Resident chairs. j. IV poles. k. Blood Pressure cuffs. l. Sink faucets. m. Light switches. n. Doorknobs and levers. 12. Horizontal surfaces with infrequent hand contact (windowsills and hard surface flooring) in routine resident-care areas should be cleaned: a. On a regular basis. b. When soiling and spills occur. When a resident is discharged from the facility. 13. Cleaning of walls, blinds and window curtains will be conducted when visibly soiled. During a tour of the South and North Halls on 9/3/2025 beginning at 8:30 AM, an observation was made of the outside patio/porch area through the door on the front side of the building. Several chairs with teal-colored cushions were observed in this area. The cushions were observed with black and green matter on them, and the patio area was observed with debris in need of attention. The area at the same end of the hall as the patio/porch area was observed with dirty blinds, the windowsill and the window well contained cobwebs, dead insects, and other debris. Stop sign banners with Velcro strips used on the doorways of resident rooms throughout the North Hall were observed to be soiled in a dirty black color, approximately covering one third of the banner. The South Hall shower room was observed to have missing floor tiles and with scattered debris on the floor. The shower room was cluttered with boxes of incontinence briefs stored on the floor alongside large gray storage units. There were two bathtubs containing debris, empty boxes and boxes of trash bags stored inside. At the entrance and exit of the shower room there was an accumulation or buildup of a black substance. On 9/3/2025 at 8:53 AM, above the nurse's station on the South Hall there were four ceiling tiles with water marks, gray to black in color. One of the ceiling tiles was observed to have a large area of a black substance. Observation on 9/4/2025 at 10:10 AM with the Administrator, she viewed the ceiling tiles above the nurse's station on the South Hall. The Administrator acknowledged that the ceiling tiles were with dark discoloration. She stated that the Maintenance Director (MD) kept the tiles changed and that the discoloration was caused by air conditioner condensation on the roof. Observation on 9/3/2025 at 9:20 AM of the resident dining room revealed scattered debris on the floor of the dining room. The lower portion of the wall just inside the door on the south side of the dining room was observed with dried, scattered, brownish colored splatters in need of cleaning. The windowsills were observed with office paper hole punches sitting on the sill and scattered condiment packages of honey, ketchup, mustard, and a pink pack of Sweet Plus (a packaged sweetener). The blinds on the windows in the dining room had a heavy accumulation and buildup of grime/dust. The dining room table chairs, along the back of the seat portion and at the base of the rungs, had an accumulation of dirt/dust and grime and were in need of cleaning. The legs of the tables were observed with food splatters. Near the ice machine and kitchen dish area window, two benches were observed, one turned upside down on top of the other. The underside of the bench on top contained an old paper towel, straw papers, and a sweetener package. There was a build-up of dust and grime along the floor of the north doorway entry/exit and there were scattered dry splatters on the lower portion of the wall on the north side of the dining room. Observation of the North Hall on 9/3/2025 at 9:35 AM revealed at the entrance to R3's room, there was a white mesh banner with a stop sign in the center. The right side of the banner was observed lying on the floor and was observed to be soiled with a dark grayish to black color. R3's wheelchair was observed parked beside his/her bed and was observed with a cushion in</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observations, record review, and resident and staff interviews, the facility failed to ensure staff provided nail care for one of four residents (Resident (R) 3) observed for the provision of ADL (activities of daily living) care out of a total sample of 24 residents resulting in dirty, long, and jagged nails. Findings include: Review of the admission Record located in the electronic medical record (EMR) was admitted to this facility with diagnoses including but not limited to major depression. Review of R3's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/20/2025 identified him as having a Brief Interview for Mental Status (BIMS) score of five out of 15, indicating R3 was severely cognitively impaired. The MDS also identified R3 as needing partial to moderate assistance with personal hygiene. Review of R3's Care Plan tab in the EMR revealed a care plan dated 7/3/2024 identifying R3's refusal for care. Nursing interventions include: Encourage resident to accept care. If refusal occurs, wait and approach at a later time. Review of the documentation in the electronic software utilized by the facility for documenting care, the task for Personal Hygiene from 5/8/2025 through 9/4/2025 was reviewed. During this time frame, documentation revealed that R3 received care and was either independent, received limited assistance, or received total assistance in the receipt of personal hygiene. The staff did not document during the 9/3/2025 to 9/4/2025 timeframe that R3 refused care for personal hygiene but did have care provided on both days. On 9/3/2025 at 9:35 AM, R3 was observed in his room in bed lying on his right side. R3's fingernails were observed to be long and jagged with a brown substance observed underneath the nails. On 9/3/2025 at 12:21 PM, R3 was asked if this surveyor could see his nails. R3 showed the surveyor his nails and the nails were in the same condition as the previous observation. On 9/4/2025 at 8:28 AM, R3 was observed coming back from breakfast. When asking about R3's clothing, R3 stated he got a bath the previous day (Tuesday) and changed his clothing. During an interview on 9/4/2025 at 3:40 PM, the Assistant Director of Nursing (ADON) provided the care plan regarding refusals for R3. While the care plan addressed refusals, it was not specific to personal hygiene or nail care. The ADON was notified that on 9/3/2025 and up to the time of this conversation, that R3's nails had been observed to be long and jagged, with brown matter underneath. The Administrator walked up to this conversation and was notified as well about R3's nails and stated staff would take care of R3's nails.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observations, staff interviews, record review, and review of facility policy, the facility failed to supervise one of one (Resident (R)1) of 24 sampled residents at risk for elopement, resulting in R1 eloping from the facility. The failure had the potential to cause harm to R1 while out of the facility unaccompanied. Findings include: Review of the facility's policy titled, Elopement of Patient dated 5/10/2022 revealed the definition of elopement as occurs when a patient leaves the premises or safe area without prior authorization. Review of R1's electronic medical records (EMR) revealed that R1 was admitted to the facility with diagnoses that include but not limited to dementia with behavioral disturbance, anxiety disorder, type two diabetes, seizures, schizophrenia, and bipolar disorder. Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/26/2024 revealed a Brief Interview for Mental Status (BIMS) score of five out of 15, indicating severe cognitive impairment. Per this MDS, R1 wandered during the assessment period, and required supervision for ADL's, redirect, and supervision on and off the unit. Review of a Nursing Note in the EMR dated 11/25/2024 revealed that R1 was admitted from a family residence and was alert to self only, confused to place and time. According to this Nursing Note R1 was offered different activities but would refuse and R1's wandering occurred frequently. Review of an Elopement Evaluation completed on 11/25/2024 and located in the Assessment tab of the EMR, also identified that R1 was at risk for elopement. R1, who was able to ambulate independently without a walker or wheelchair, had risk factors including diagnosis (dementia), a history of wandering, the inability to locate significant landmarks without assistance, and attempts of routine/leisure interests that were not consistent with their new environment which could lead to exit-seeking behaviors. The Elopement Evaluation noted that the resident's behaviors included hovering near exits, as well as hyper, frustration, and restlessness and/or agitation. Review of R1's Comprehensive Care Plan, initiated on 11/25/2024, revealed R1 was care planned to prevent elopements from the day of admission. The goal for R1 to not leave the facility unattended was to be met through multiple interventions, including: Observe risk factors/triggers for exit seeking behavior and adjust care. Staff monitor [R1] frequently. [R1] photo to be in Elopement Risk book, [R1]/family member to utilize check/out logbook and Facility has exit alarms. Review of a facility document titled, Self-Reported Incident Form, dated 5/1/2025, revealed that R1 eloped from the facility on 4/30/2025. It was reported that [R1] had exited the facility unsupervised and was located off facility property. Procedures related to a missing resident were initiated and followed. During the facility search, staff were able to locate eighty-three of eighty-four residents. Charge Nurse Licensed Practical Nurse (LPN)4 notified the Administrator, local police, and family members. Observations during a tour of the facility on 9/3/2025 at 8:41 AM revealed that the secured North residential unit included one wing with resident rooms, a day area, and a central nursing station. The residential unit had four exits accessible to residents and staff, one of which led to a locked hallway, then to the main entrance. The main entrance was locked and required a code to get in and out of the facility. Two of the other locked doors led into other areas of the facility. The fourth locked side door was an exterior door opening to the parking lot. This side door was used by employees entering and exiting the facility and required a code to get in and out. Interview on 9/4/2025 at 10:10AM, the Administrator stated that there was a video tape of the incident where LPN4 opened the side door to admit Recreational Therapist (RT)1 but did not supervise R1 and R1 walked past both RT1 and LPN4, exiting the facility. This surveyor requested copies of the written facility investigation, including statements from LPN4 and RT1. The Administrator advised that written statements did not exist. A request was made to see the video tape of the incident. The Administrator stated that after ten days, the videos were recorded over, so the video of the incident no longer existed. On 9/4/2025 at 11:30AM, the Administrator and the Maintenance Director (MD) produced the video of the incident. The MD had a copy of the video in an email he sent to the police department. The video showed LPN4 opening the side door to admit RT1 and R1 walking past both, exiting the facility. The video did not contain a date stamp or a time stamp, but it did show the sun setting in the background. Interview on 9/3/2025 at 3:45PM, LPN4 stated she opened the door for RT1. [RT1] walked in as I was walking away. At no time did LPN4 see R1 exit the facility. LPN4 stated that during the medication pass around 8:00 PM that day, another staff member alerted the team that R1 could not be located. LPN4 said that all staff members did a sweep throughout the facility, and R1 could not be located. LPN4 then notified the Administrator, the Social Services Director, the police department, and the family member. Interview on 9/4/2025 at 12:45 PM by telephone RT1 stated that around 6:30 PM or 7:00 PM he arrived at the facility and LPN4 opened the</p>		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observations, staff interviews, record review, and facility policy review, the facility failed to ensure expired insulin pens and insulin vials were removed from two of four medication carts (South Hall long and South Hall short) reviewed. In addition, the facility failed to ensure two of two medication room refrigerators (North Hall and South Hall) were locked and the schedule II lock box (containing narcotics that have a high incidence of abuse) were affixed to shelving, as required. This failure had the potential of medication diversion to residents, staff or visitors, and residents receiving ineffective medications. Findings include: Review of the facility policy titled, Medication Storage in the Facility, Expiration Dating of Medications, dated February 17, 2020, revealed, .Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. Injectable medication dispensed by pharmacy will be discarded thirty (30) days after initial dose or according to the manufacturer recommended discard date. The medication will be noted with the date the medication was initially opened. Review of the facility policy titled, Medication Storage in the Facility, Storage of Medications, dated June 1, 2018 revealed, .Schedule II, III, IV, and V controlled medications are stored separately from other medications in a locked drawer or compartment designated for that purpose. All medications dispensed by the pharmacy are stored in the container with the pharmacy label. The nurse will check the expiration date of each medication before administering it. No expired medications will be administered to a resident. 1. During an observation of the South Hall Medication Room on 9/3/2025 at 3:10 PM with Licensed Practical Nurse (LPN) 7 revealed the medication room refrigerator was unlocked and the narcotic lock box was inside the refrigerator and not affixed to the shelving. The locked narcotic box revealed five vials of lorazepam (a medication used to treat anxiety and agitation-a scheduled IV (four) medication) was inside. In addition, the refrigerator shelves on the door and the floor of the refrigerator were noted with debris and a yellowish sticky substance. LPN7 confirmed that the locked box was not affixed, and the refrigerator was dirty. During an observation of the North Hall Medication Room on 9/3/2025 at 3:25 PM with LPN5 revealed the medication room refrigerator was unlocked and the narcotic lock box was locked but was not affixed to the shelf in the refrigerator. The narcotic locked box contained 12 vials of lorazepam. LPN5 confirmed that the locked box inside the refrigerator was not affixed to the shelving. 2. Review/observation of the South Hall Short Medication Cart on 9/4/2025 at 8:19 AM with LPN 6, who administered medications from the Short Hall cart, revealed one Lantus (long-acting insulin) kwik pen without a name, date when opened, and/or expiration date on the pen. The kwik pen showed a full vial was 260 units however, the vial showed 80 units. LPN 6 confirmed that the kwik pen did not have a resident's name on it and had been used but did not know which staff was using the unlabeled pen. LPN6 stated she did not know for certain which resident was receiving the insulin from the kwik pen but R17 was the only resident receiving Lantus from that medication cart. Review/observation of the South Hall Long Medication Cart on 9/4/2025 at 9:08 AM with LPN 8 revealed the following: 1. A Tresiba insulin (long-acting insulin) kwik pen with an expiration date of 8/21/2025. 2. A vial of Lantus insulin with an open date of 7/18/2025 and expiration date of 8/18/2025. 3. A vial of Lispro insulin (short-acting insulin) which was not dated when opened or had an expiration date listed on the vial but had been used. 4. A vial of Lispro insulin which was opened which had an open date of 7/30/2025 and an expiration date of 8/27/2025. 5. There was one vial of Lantus insulin and one vial of Lispro insulin that were unopened and unused, however, the label stated that it was to be refrigerated until opened. LPN 8 stated during the observation that the insulins were expired and should not have been used. LPN 8 further stated that insulin should be refrigerated until opened. During an interview on 9/5/2025 at 9:35 AM, the Assistant Director of Nursing (ADON) stated that insulins should not be used after the expiration date and the medication room refrigerators were to be locked.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observations and staff interviews, the facility failed to ensure a safe, functional, sanitary, comfortable environment in the clean linen room, the overflow Linen Room, the Biohazard Room, and the South Hall Medication Room were maintained in an clean, orderly, and sanitary manner. Findings include: Observation on 9/3/2025 at 8:55 AM, at the nurse's station near the shower room on the South Hall revealed empty cardboard boxes along the wall. A plastic cup and scattered debris to include a cotton ball and paper were observed on the floor of the nurse's station. Between the supplement room where the nourishment refrigerator was located and the locked medication room, five boxes of opened and unopened boxes of Med Pass 2.0 and Ensure nutritional supplements were observed stacked up on the floor. On 9/3/2025 at 9:00 AM, at the request of the surveyor, Licensed Practical Nurse (LPN)8 unlocked the Medication Room. Multiple items were observed on the counter in disarray and cluttered to include a clear box with medications inside. The lid was lying on the top due to the box being over filled. The floor in the Medication Room was observed with scattered debris as well as crumbs located along and underneath the cabinets. Observation on 9/3/2025 at 9:05 AM of the Nourishment Room on the South Hall behind the nurse's station revealed the inside of the refrigerator containing nutritional supplements and other food items was in disarray and the refrigerator and freezer were observed with sticky substances, in need of cleaning. On 9/3/2025 at 10:50 AM, the Assistant Director of Nursing (ADON) was asked to accompany the surveyor to the Biohazard Room. The Maintenance Director (MD) provided entry to the Biohazard Room. Upon entry into the locked and labeled room, immediately to the left was a hopper with dark gray water standing in the bottom. The hopper was in need of cleaning as there was a black substance around the rim. The hopper was observed to wobble and was not secured to the structure. Trash and other debris was observed on the floor to the left side of the hopper with an accumulation of dirt and grime on the floor and a black substance on the baseboard. To the right of the hopper, two 1-gallon containers of a chemical, a 5-gallon bucket of floor wax, a sharps container containing sharps/needles, and a red biohazard bag containing sharps containers were observed on the floor. A wet floor sign, and a small trash container with red biohazard bags stored inside were also observed in this area. Behind the door to this room, there were 12 sharps containers stacked on the floor with sharps inside. The entire floor of this room had a buildup of a dark graying/black grime. During this observation, a room attached to the Biohazard Room was observed to be open and without a door handle. When the ADON was asked what was behind the door, she stated it was where overflow laundry was kept. The threshold between the two rooms was observed with a buildup of debris. Upon entering the room, laundry was observed on the floor. The floor of this room was observed to have a buildup of dirt and grime, grayish black in color. There were laundry racks full of laundry on both sides of the room. Although the laundry racks including sheets and towels were covered with fabric covering, the laundry was falling off the racks onto the floor. The ceiling light cover was observed to have an accumulation of dead bugs. Empty boxes were observed on the floor toward the back of the room near the door along with a black trash bag on the floor. The MD stated that there were extra hangers in the trash bag. There was a large amount of grayish black debris near the base of the door along with a large amount of cobwebs and dead bugs. There was light coming in around the exit door leading to outside that may allow the entry of bugs and pests. Observation of the clean laundry room on 9/3/2025 at 11:00 AM with the ADON, revealed laundry on the floor, some appearing dirty with brown stains. There were plastic bags of laundry on the floor, two IV (intravenous) poles were sitting on top of a plastic bag of laundry and other linen on the floor. There was a box labeled name of medical supply company turned on its side at the back of the clean laundry room among the laundry on the floor. A weighing device on its side and a dolly stored in the room near the laundry was observed on the floor. Behind the entry door, there was a brownish buildup of grime on the floor. On 9/3/2025 at 11:05 AM, the Administrator was notified about the findings in the Biohazard Room, the clean laundry, and the overflow laundry rooms. During an interview on 9/4/2025 at 10:30 AM, the Housekeeping Director (HKD1), when asked about the clean linen room, verified the condition of the clean linen room and that she took full responsibility.</p>		