STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Market Square Health Care Center, LLC	3 Market Square South Paris, ME 04281

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review, interviews, and facility policy, the facility failed to thoroughly investigate a resident's injury of unknown origin for 1 of 3 facility-reported incidents (Resident #27).Finding:Facility policy Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property, revised 10/18 states, under section E. Investigation, .Procedure: The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration. Investigation of injuries of Unknown Origin or Suspicious injuries: The facility may initially evaluate an occurrence to determine whether it meets the definition of an ?alleged violation'. upon discovery of an injury, the facility must immediately take steps to evaluate whether the injury meets the definition of an injury of unknown source.On 2/21/26 at 1:10 p.m., the State of Maine's Division of Licensing and Certification (DLC) received a facility-reported incident that indicated that staff was providing care to Resident #27 and noticed that he/she had a small bruise on the inside of his/her left thigh. The initial report indicated that Resident #27 could not recall how he/she got the bruise. The DLC did not receive a follow-up report.A review of Resident #27's clinical record revealed a nursing progress note dated 2/20/26 that states, CNA [Certified Nursing Assistant] during rounds and PM [evening] care CNA reported unknown source of injury. Writer observed resident in bed with discolored skin to left inner thigh noted. Resident unable to answer question of what happened.Resident remains safe in bed at this time, and no reports noted from previous shift of fall/incident. Administration/on call nurse notified of findings.A nursing progress note, dated 3/4/26 states, Resident was noted to fall back onto the arm of [his/her] recliner landing on [his/her] left thigh assisted resident to sit on recliner correctly.On 5/12/26 at 1:16 p.m. during an interview with the Director of Nursing (DNS), a surveyor discussed the lack of evidence that the facility had conducted an investigation for Resident #27's injury of unknown origin. At this time, the DNS stated that she could provide the incident report and clinical notes and confirmed that the facility did not submit a follow-up report to the DLC. On 5/13/26 at 2:55 p.m., the surveyor discussed the above finding with the Administrator. During an interview at this time, the Administrator stated that she was not even aware the above incident had been submitted to the DLC and confirmed that the facility did not complete an investigation for Resident #27's injury of unknown origin. The Administrator then stated that an investigation was not conducted because the facility had already determined how Resident #27 was injuring him/herself. The surveyor then discussed that the nursing progress note indicating how Resident #27 was injuring him/herself was not dated until 3/4/26, 12 days after his/her initial injury of unknown origin.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interviews, and record review, the facility failed to ensure a resident's comprehensive care plan was developed and implemented to reflect the current needs of the resident for 5 of 18 residents reviewed for care planning (Residents #17, #38, #25, #61, #85). Findings: 1. Resident #38 was admitted to the facility in 2025 with diagnoses to include Quadriplegia. On 5/11/26 at 10:37 a.m. a surveyor observed Resident #38 sitting in a high-back wheelchair in his/her room. At this time, a Certified Nursing Assistant (CNA) entered the room and refilled Resident #38's water bottle that was part of a hands-free adaptive drinking system with a flexible arm and mouthpiece, located on the back of his/her wheelchair. During an interview, Resident #38 stated that the device allows him/her to drink independently. A review of Resident #38's clinical record revealed physician orders dated 2/9/26 and 5/5/26 for Occupational Therapy that state, Therapeutic Exercise; Therapeutic Activities; Self Care/Home Management Training; Neuro Re-education; Wheelchair Management; Group Therapy. Duration 12 weeks. A review of Resident #38's comprehensive care plan lacked evidence that goals and interventions were developed and implemented related to the occupational therapy services Resident #38 is receiving, including his/her use of adaptive devices. On 5/14/26 at 9:30 a.m. during an interview, the Occupational Therapist (OT) stated that Resident #38 has been receiving occupational therapy services since admission to the facility. On 5/14/26 at 12:30 p.m., the surveyor discussed the above finding with the Director of Nursing (DNS), Assistant Director of Nursing, and the [NAME] President of Clinical Services. During an interview at this time, the DNS stated that the facility has never included goals and interventions related to therapy services on a resident's care plan for any of the facility's residents receiving physical therapy (PT) or OT. 2. On 5/11/26 at 11:05 a.m. a surveyor observed Resident #17 lying in bed in his/her room with his/her call light on. During an interview at this time, Resident #17 stated that he/she had called for a bedpan and that CNA #11 was supposed to go to supply and get another bedpan but never returned. At 11:10 a.m., three staff members entered Resident #17's room to respond to his/her call light and stated that CNA #11 is on break but that they would go find a bedpan. At 11:14 a.m., CNA #11 entered Resident #17's room alone and stated that she had forgotten about Resident #17's bedpan and then proceeded to assist Resident #17 to use the bedpan alone. A review of Resident #17's comprehensive care plan states, .Behavioral Symptoms: [Resident #17] has physical behavioral symptoms directed at others .All care should be provided with 2 staff members. On 5/13/26 at 1:14 p.m. a surveyor observed Resident #17's call light on, and at this time, the Activities Director asked the Social Services Assistant to accompany her to answer the call light. During an interview at this time, the Social Services Assistant stated that for the safety of Resident #17 and the safety of the staff, two staff are to be present for all interactions with Resident #17. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/13/26 at 2:10 p.m. the surveyor discussed the above finding with the Administrator. 3 Review of facility policy, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property. revised 10/18 states, Prevention . The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as: Verbally aggressive behavior, such as screaming, cursing .Physically aggressive behavior such as hitting, kicking, grabbing .threatening gestures . On 9/8/25 at 2:22 p.m., the Division of Licensing and Certification (DLC) received a facility-reported incident that stated that Resident #61 .rolled from out of [his/her] room after eating lunch, yelled and cursed at [Resident #89] for being in [his/her] way, threatening to run [Resident #89] over in [his/her] wheelchair. The follow-up report submitted to the DLC on 9/15/25 indicated that Resident #61 .used her motorized wheelchair to push [Resident #89] out of [his/her] way and then ran over [Resident #89's] foot rather than wait for staff to move [him/her]. A review of Resident #61's clinical record revealed the following: A progress note dated 3/12/25 that states, It was reported to me by CNA. that Resident backed over another resident's feet in [his/her] wheelchair this morning .Resident is usually grouchy and mean with others. Plan of care ongoing. A progress note dated 7/19/25 that states, Resident was in the lobby area watching TV when another resident tried to get around [him/her] in [his/her] wheelchair. This RN [registered nurse] saw resident kick the other person very hard and started yelling and swearing. A progress note dated 7/29/25 that states, resident became verbally aggressive to another resident and to said nurse. states [he/she] will punch another resident in the face if [he/she] touches [him/her]. redirected resident. A progress note dated 9/5/25 that states, .Resident was sitting in the common area with other residents present when she started yelling and shouting SHUT UP! SHUT UP! to another resident with dementia. Staff separated residents. Writer reported. behaviors to DON/MD [Medical Doctor] for further review of behavior displayed in front of visitors, resident and staff. No further behaviors noted at this time. Care plan continued. A progress note dated 2/9/26 that states, Another resident was rolling [his/her] wheelchair past where this resident was sitting when [he/she] gave the wheelchair a kick. Staff immediately intervened without any further incident. No injury on either resident. This resident was redirected. A review of Resident #61's comprehensive care plan lacked evidence that goals and interventions were developed and implemented for his/her verbal and physical behaviors towards others. On 5/14/26 at 1:28 p.m. during an interview in the presence of 3 surveyors, the DNS stated that Resident #61 has always disliked residents with dementia to be around him/her, so the facility tries to keep an eye out on residents with dementia who are trying to get around near Resident #61 to prevent any incidents from arising. At this time, a surveyor discussed that Resident #61's care plan lacks goals and interventions for his/her history of resident-resident conflicts. At this time, the DNS confirmed that interventions should have been in place on Resident #61's care plan to address his/her behaviors. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.Resident #85 was admitted 5/2026 for skilled services. Review of Resident #85 orders revealed order with start date of 5/5/26 for PT [Physical Therapy] - Treatment Clarification orders: Therapeutic Exercise: Therapeutic Activities: Gait training: Neuro re-education; wheelchair management. Frequency 60 Duration 12 weeks. Review of Resident #85's care plan created 5/4/26 lacked goals and interventions in the area of therapy services. Interview with Occupational l Therapist (OT) on 5/12/26 11:09 a.m. Confirmed Resident #85 received PT and OT services 5 days a week and stated they have a therapy plan of care for him/her, but it should be transferred into the resident's care plan. 5. Review of Resident #25's clinical record revealed he/she sustained an unwitnessed fall on 5/11/26. Review of his/her care plan for falls revealed an intervention stating, Needs will be met while completing hourly rounding. On 5/14/26 at 7:10 a.m., during an interview with Certified Nursing Assistant #9 stated Resident #25 is on hourly rounding for fall precautions, stating they document this on a rounding sheet kept at the nurse's station. On 5/14/26 at 8:06 a.m., a review of Resident #25's Hourly Rounding Sheets for 5/12/26 and 5/13/26 revealed 14 missing rounds. On 5/14/26 at 8:35 a.m., the above information was reviewed with the Facility Administrator.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interview, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a food mixer, food storage bins, the ceiling, the hood system, a door, and floors; failed to ensure foods were sealed, labeled and/or dated on kitchen carts and in a walk-in freezer for 2 of 2 kitchen/kitchenette tours for 1of 4 days of survey (5/11/26); and failed to ensure Daily High-Temp Ware Wash temperatures, the Freezer and Refrigerator Temperatures, and Sink/Bucket Sanitizer and 3-Bay parts per million(PPM) were monitored/documented for 1 of 4 days of survey. (5/12/26) Additionally, the facility failed to serve food in in sanitary manor for 1 of 4 days of survey. (5/11/26)Findings: Food Storage policy and procedure dated 2023 noted: Procedure: 8. All containers or storage bags must be legible and accurately labeled and dated. 12. Leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated. 13. Refrigerated food storage: f. All foods should be covered, labeled and dated and routinely monitored to assure that foods will be consumed by their use by dates, or frozen or discarded. 14. Frozen Foods: c. All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their use by dates or discarded. Dish Machine Temperature Log policy and procedure dated 2023 noted: Policy: Dishwashing staff will monitor and record dish machine temperatures to ensure proper sanitizing of dishes. 2. Staff will Record dish machine temperatures for the wash and rinse cycles after each meal. The director of food and nutrition services will spot check this log to assume temperatures are appropriate and staff is correctly monitoring dish machine temperatures. 1. On 5/11/26 from 8:10 a.m. to 8:50 a.m., a surveyor conducted an initial kitchen tour with a cook and the Food Service Director(FSD) in which the following findings were discussed and observed: - The food mixer had dried food particles and dried liquid residue on the shroud, cage and base. Additionally, the mix arm had chipped/missing paint creating an uncleanable surface. - There was a large bin of cereal that was not date and labeled. - There was a large bin of sugar and a large bin of flour that were not dated. - The ceiling over food preparation areas had dried food and liquid residue spattered on it. - The hood system was missing filters and the exhaust area was dusty/dirty. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- There was a bag of bread products, on a cart by the coffee maker, that was not labeled and dated. - There were six bags of bread products, on a cart labeled first-in first-out, that were not labeled and dated. - The dish room door and frame, that exits to a hallway, was rusty and had chipped/missing paint creating uncleanable surfaces. - The food disposal had dried liquid residue on it. - The walk-in refrigerator had a cement floor that had worn off/missing paint and was not sealed creating an uncleanable surface. - The walk-in freezer had a bag of carrots, a bag of French fries and a box of chicken patties that were previously opened and left open to the air and not secured. Additionally, there was a large bag of tater tots that was not labeled and dated. On 5/11/26 at 8:50 a.m., in an interview with a surveyor, both the cook and the FSD confirmed the findings. 2. On 5/11/26 at 12:00 p.m., a surveyor observed the refrigerator, in the main dining room, had spilled liquid residue on the unit shelving. On 5/11/26 at 12:05 p.m., in an interview with a surveyor, a kitchen worker observed and confirmed the finding. 3. On 5/12/26 at 3:00 p.m., a surveyor reviewed the kitchen dish washer logs, the sanitation bucket logs and the kitchen/kitchenette refrigerator/freezer temperature logs and found dates that were not monitored/documented and were missing in February, March and April of 2026. Daily High-Temp Ware Wash checklist: 2026–Missing dates February- no evidence of documentation March 30th and 31st for lunch Freezer and Refrigerator Temperatures Form: 2026 –Missing dates March Dining room freezer: 29th, 30th. East/West Unit: p.m.-29th, 30th. April Tuttle Unit: a.m.- 26th, 30th; p.m.-25th, 26th, 27th, 30th. East/West Unit: a.m.- 22nd, 23rd, 30th.; p.m.-22nd, 23rd, 25th, 26th, 27th, 30th. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dining Room: a.m.-30th,; p.m.-22nd, 23rd, 25th, 26th, 27th, 30th. Kitchen Freezer: a.m.-30th. Kitchen Walk-in: a.m.-30th. Sink/Bucket Sanitizer: Kitchen 2026–Missing dates February - early morning-27th, 28th.; mid-morning-27th, 28th.; afternoon- 26th, 27th, 28th.; evening-26th, 27th, 28th.; March: early morning-28th-31st.; early morning-27th-31st.; afternoon- 4th-30th,; evening- 4th-30th. April: no evidence of documentation Bucket Sanitizer: Kitchen 2026–Missing dates February - early morning-27th, 28th.; mid-morning-27th, 28th. March: no evidence of documentation April: no evidence of documentation On 5/12/26 at 3:10 p.m., a surveyor discussed the findings with the Administrator. 4. On 5/11/26 observation of breakfast meal tray pass showed the following at 8:23 a.m., CNA #5 (Certified Nursing Assistant) carrying a tray containing uncovered food down the hall to room [ROOM NUMBER]. At 8:28 a.m., CNA #4 carrying a tray containing uncovered foods down the hall to room [ROOM NUMBER]. At 8:30 a.m., CNA #5 carrying a tray containing uncovered foods down the hall to room [ROOM NUMBER]. At 8:31 a.m., CNA #3 carrying a tray containing uncovered foods down the hall to room [ROOM NUMBER]. At 8:34 a.m., CNA #3 carrying a tray containing uncovered foods down the hall to room [ROOM NUMBER]. On 5/11/26 at 8:36 a.m., during an interview with Dietary Aid #1, he discussed the process of prepping trays prior to bringing them down the hall to resident's rooms, stating all food items are supposed to be covered or packaged. At this time, he confirmed he has not been covering all the food on the resident's meal trays. On 5/11/26 at 8:38 a.m., in an interview with the Director of Nursing Services, the above information was discussed and confirmed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy, the facility failed to maintain an Infection Control Program designed to provide a sanitary environment to help prevent the development and transmission of disease and infection related to the use of Personal Protective Equipment (PPE) while providing care for a resident on Enhanced Barrier Precautions (EBP), sanitizing glucometers, linen handling, hand hygiene during resident care, and applying transmission based precaution for 3 of 4 days of survey (5/11/26, 5/12/26, 5/13/26). Additionally, the facility failed to conduct an annual review of its Infection Prevention and Control Program (IPCP). Findings: 1.Observation of Enhanced Barrier Precautions (EBP) room [ROOM NUMBER] on 5/13/25 at 9:50 a.m., Certified Nursing Assistant (CNA)#7 was observed opening the door with her ungloved, left hand, and holding a full trash bag in her ungloved right hand. CNA#7 was not wearing a gown. At this time a surveyor asked CNA#7 if she had been wearing the required Personal Protective Equipment while caring for the resident in the room. CNA#7 replied that they wore gloves, but not the gown. CNA#7 was able to state why the resident was on EBP precautions and what precautions she was supposed to wear. Observation inside the room revealed second CNA#12 at residents' bedside ungowned, ungloved and using her bare hands to place soiled linen into a plastic bag. Observation of sign hanging outside of room [ROOM NUMBER] states: Enhanced barrier Precautions: Everyone Must: clean their hands, including before entering and when leaving the room; Providers and staff must also: wear gloves and a gown for the following High contact Resident care activities: Dressing, bathing/showering; transferring; changing linens; providing hygiene; changing briefs or assisting with toileting: Device care or use: central line, urinary catheter, feeding tube, tracheostomy; wound care: any skin opening requiring a dressing. On 5/13/26 at 10:13 a.m., the above was discussed with Administrator. 2. On 5/11/26 at 12:34 p.m., observation of LPN #3 (Licensed Practical Nurse) walking out of Resident #24's room with a glucometer. He is then observed putting the glucometer in the treatment cart and locking the drawer. Upon interview with LPN #3, he states he just checked Resident #24's blood sugar. When asked how often glucometers are cleaned, he stated after each use. Upon further interview, LPN #3 stated he did not clean the glucometer after using it on Resident #24. LPN #3 is then observed taking the glucometer out of the treatment cart and cleaning it. On 5/11/26 at 1 p.m., the above information was discussed with the Director of Nursing Services and the Facility Administrator. 3. Facility policy Hand Hygiene Policy and Procedure dated 11/2025 states, .Indications for Handwashing and Hand Rubbing. Handwashing may also be used for routinely decontaminating hands in the following clinical situations but not limited to. Before having direct contact with patients.After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.After removing gloves. Gloves and Hand Hygiene. the use of gloves does not eliminate the need for hand hygiene. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before caring for another patient. Decontaminate hands after removing gloves. On 5/11/26 at 12:20 p.m., a surveyor observed CNA #1 enter Resident #23's room and don (put on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves). CNA #1 then removed Resident #23's fall mat located on the floor next to his/her bed and proceeded to fold the mat and place it against a cabinet. Then, without doffing (removing) her gloves or sanitizing her hands, CNA #1 assisted CNA #2 to transfer Resident #23 from his/her bed to his/her wheelchair. CNA #1 then positioned Resident #23's wheelchair in front of his/her over-the bed table and without doffing the gloves or sanitizing his/her hands, began to lift the cover from Resident #23's meal plate. At this time, the surveyor intervened. During an interview at this time, CNA #1 stated that Resident #23 is usually already in his/her wheelchair so she does not have to sanitize her hands and that they want us to pass the trays as quickly as possible, so she did not sanitize her hands. At this time, the surveyor requested that CNA #1 sanitize her hands, and CNA #1 proceeded to doff her gloves and sanitize her hands. On 5/11/26 at 12:48 p.m., the surveyor discussed the finding with the [NAME] Unit Manager (UM). On 5/11/26 at 1:08 p.m., the surveyor discussed the finding with the Administrator. 4. Facility policy, Linen Handling Policy, developed February 23, 2021, states, .Soiled linen is considered to be potentially contaminated and standard precautions will be used when being handled. Gloves will be worn when handling soiled linens. Linens will be bagged (a pillow case may be used) at the point of collection (resident room) and then soiled linens are transported to laundry bins. Soiled linen should not be held against employee clothing . Transporting laundry: When transporting soiled laundry, measures will be taken in order to prevent cross-contamination. Contaminated linens and laundry bags will not be held close to the body . Bagging/containing contaminated linen where it's collected . On 5/12/26 at 3:06 p.m., two surveyors observed CNA #10 transport a shower chair containing a pile of unbagged soiled linens and 2 bags of trash out of a resident's room on the [NAME] unit to the Whirlpool Room. CNA #10 then wheeled the chair into the shower room, gathered the trash bags and soiled linens, and started the shower to rinse the chair. CNA #10 proceeded to exit the shower room and walk to the Soiled Utility room with the unbagged soiled linens held against her body. CNA #10 then discarded the linens in the bin and after sanitizing her hands, exited the Soiled Utility room. During an interview at this time, the surveyors discussed the above observation with CNA #10. CNA #10 stated, I know the rule and confirmed that she held unbagged soiled linens against her body and stated that she would change her shirt. On 5/12/26 at 3:10 p.m., the surveyors discussed the above finding with the DNS. 5. On 5/11/26 at 8:50 a.m. a surveyor observed a Stop sign hanging on Resident #51's door frame, and a cart containing PPE was located outside of his/her room. The reverse side of the Stop sign indicated EBP. The PPE cart lacked any additional signage. On 5/11/26 at 8:57 a.m. during an interview, LPN #1 stated that Resident #51 has an ESBL (Extended Spectrum Beta Lactamase- a type of antibiotic-resistant bacteria) Urinary Tract Infection (UTI). When the surveyor asked what type of precautions were in place, LPN #1 stated that Resident #51 is on contact precautions and then stated that he wanted to clarify that. LPN #1 then asked the [NAME] UM, and she stated that Resident #51 is on EBP. A review of Resident #51's clinical record revealed the following active physician orders: An order with a start date of 5/6/26 for doxycycline hyclate 100 mg capsule 2 Times Daily for 5 Days (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for Urinary Tract Infection An order with a start date of 3/17/26 for Cephalexin 250 mg capsule 1 Time Daily for history of UTI Resident #51's nursing progress note, dated 5/8/26 states, .continues with PO [oral] ABT [antibiotic therapy] Doxycycline related to UTI. A review of Resident #51's laboratory sensitivity results dated 5/6/26 states Escherichia coli ESBL and were acknowledged by the physician's signature on 5/7/26. Further review of Resident #51's clinical record, including his/her care plan and active physician orders lacked evidence that Resident #51 was on contact precautions or EBP. On 5/12/26 at 2:18 p.m. during an interview, the DNS confirmed that Resident #51 has an ESBL UTI and is currently being treated for with Doxycycline and that the cephalexin order is prophylactic treatment for recurrent UTIs. The DNS then stated that Resident #51 should have been placed on contact precautions from the date the UTI was diagnosed. On 5/13/26 at 3:27 p.m. during an interview with the Infection Preventionist (IP), the surveyor discussed the above finding. At this time, the IP stated that she had reached out to the doctor and called the lab and that nothing on Resident #51's preliminary results indicated ESBL and that EBP was in place until yesterday when Resident #51 was placed on contact precautions. The IP then stated that someone must have known that Resident #51 was on contact precautions because PPE carts outside of resident rooms are designated for residents on contact precautions. 6. On 5/12/26, initial review of the facility's infection control policies included the following: Facility policy, Infection Control Immunizations- Influenza, Pneumococcal, Covid Policy, developed April 2007, last revised 12/24 Facility policy, Infection Control: Core Elements of Antibiotic Stewardship Policy, developed April 2007, last revised 8/24 Facility policy Hand Hygiene Policy and Procedure, developed 11/2025, lacks review or revision date Facility policy, Infection Control/Management of Clostridium Difficile Resident Policy, dated April 2007, revised 10/24 Facility policy, Linen Handling Policy, developed February 23, 2021, lacks review or revision date Facility Policy, Infection Control/Exposure Control Plan, developed April 2007, revised 5/14/24, and states under Program Evaluation The effectiveness of the Infection Prevention and Control Program is reviewed no less than annually . On 5/13/26 at 4:36 p.m. during an interview with the IP and in the presence of the [NAME] President (VP) of Clinical Services and another surveyor, a surveyor discussed that the above IPCP policies lacked evidence of annual review. At this time, the VP of Clinical Services stated that all IPCP policies are reviewed annually but that the review date may not necessarily be reflected on the policy unless it was revised. At this time, the surveyor requested evidence of the facility's annual review of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205076	A. Building B. Wing	05/14/2026

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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	its IPCP. On 5/14/26 at 3:01 p.m. during an interview in the presence of 2 surveyors, the Administrator confirmed that the facility's IPCP was last reviewed 1/29/25 at the Quality Assurance and Performance Improvement (QAPI) meeting and that the IPCP was supposed to be reviewed at the beginning of 2026, but there were conflicts with the pharmacist consultant and the medical director not being in attendance together. The Administrator stated that the IPCP was then scheduled to be reviewed at April's meeting, but that due to all QAPI members not attending at the same time, it was again delayed and confirmed that the facility's IPCP has not been reviewed yet for 2026.