

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Towson Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 509 East Joppa Road Towson, MD 21286	
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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview and observation, it was determined that the facility failed to provide an environment that was free of accidents and hazards for residents. This deficient practice resulted in harm to Resident #7 and was evident for 1 (Resident #7) of 2 residents reviewed for quality of care complaints and 1 (Resident #4) of 3 residents reviewed for complaints of neglect. This was also evident during random observations on 3 of 3 nursing units. The findings include: Care plan - is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Fall Risk Assessment &ndash; is a tool that facilities use to determine the level of risk that a resident has for falling. Each question on assessment is assigned points and based on the answer there is a score at the end of the assessment which indicates the level of risk the resident has for falling. A review of the facility's Fall Prevention Program dated 11/2023 and last updated in 7/2026 revealed the nurse was to complete the resident's fall risk assessment and implement interventions based on the score. A low to moderate risk they were to implement the following: evaluate the resident's environment for interventions to decrease risk; implement a rounding schedule; monitor changes in the resident's cognition, balance, gait, and ability to rise/sit; ensure resident had proper foot ware and eye ware; monitor vital signs; and complete a fall risk assessment every 90 days and when a change indicated one. If they were high risk for falls, the following interventions were to be implemented in addition to the ones indicated for the low to moderate risk section: indicate the resident was high fall risk on the fall care plan; provide interventions to address unique risk found during the fall risk assessment; provide the following as indicated on the risk assessment which included assistive devices, increasing levels of supervision, and toileting schedule to name a few. 1) A medical record review for Resident #7 on 7/20/26 at 2:25 PM revealed a history and physical examination conducted by the attending physician on 4/5/26. According to this document the resident (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 0689 Level of Harm - Actual harm Residents Affected - Few	arm bone) fracture, dementia, failure to thrive, diabetes, and heart disease. A review of the care plan for falls that was initiated on 6/19/26 revealed there were interventions in place to include frequent monitoring. On 6/19/26 the resident was found sitting on the floor next to the bed. The fall risk assessment completed on 6/19/26 after the fall revealed the nurse failed to assess the resident's balance, failed to mark the resident had a previous fracture, and failed to mark 2 of the 4 medications the resident was taking. Again due to the incomplete and inaccurate assessment, the resident scored a low risk of falls. A review of the SBARs related to falls revealed the following. The resident had a fall in the hallway on 6/21/26 and was found on the floor on 6/25/26. The fall risk assessment that was completed on 6/23/26 revealed the nurse failed to assess the resident's balance and failed to include that the resident was on a hypoglycemic medication, therefore the fall risk score was low/moderate. A fall risk assessment after the fall on 6/25/26 revealed the nurse assessed the resident's balance as unsteady but failed to include the diagnoses and that the resident was on a narcotic and psychotropic medications. With this inaccurate assessment, the resident was deemed at a high risk for falls. With a change in the level of the fall risk, a review of the care plan revealed facility staff updated the care plan on 6/29/26, 8 days after the first fall and 4 days after deeming the resident a high risk. They added the following interventions: place fall mats beside the resident's bed, make sure the wheelchair was locked, and assessing for pain. On 6/30/26 the attending physician wrote in his notes that the resident needed 1:1 supervision. However, further review of the medical record revealed no evidence of the 1:1 supervision. The resident had an additional fall on 7/5/26. On 7/16/26 at 9:00 AM there was a review of the facility's 1:1 Supervision policy that had no date that it was implemented or the last review date. The document stated that during 1:1 supervision the staff member should have visual sight of the resident and be within arm's reach. The staff member assigned was to document, the time monitoring, beginning and ending. During an interview on 7/16/26 at 9:12 AM with Unit Manager (UM) #24 she was shown the 1:1 Supervision policy and reported she was not familiar with the policy. She stated that when a resident was ordered 1:1 supervision she assigned it to a staff member on the daily assignment sheet. She stated that the assigned staff stayed with the resident and she was unaware that they were to document during the assignment. She was asked to provide evidence that the 1:1 was assigned for Resident #4. On 7/16/26 at 11:41 AM a review of the staffing assignment sheets for 5/6/26 & 5/23/26 revealed that a 1:1 was split between each nursing assistant for 2 hours at a time. The assignment sheet failed to document which resident the 1:1 supervision was assigned. Except for 1 schedule noted a room number (that was not Resident #4's room number). Each of the nursing assistants assigned had a full assignment of other residents to care for during the shift. An interview with Nursing Assistant (Aid) #25 on 7/16/26 at 12:23 PM, who had been one of the nursing assistants assigned to 1:1, revealed that when shown the schedules, she reported that it was (continued on next page)		

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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. Based on observations completed during tours of the facility on the second floor, it was determined that the facility failed to ensure the furniture provided in each resident room including dressers were functional and accessible to each resident. This was evident for 13 of 28 rooms observed on the second floor. During general observations and tour on 7/17/26 at 9:03 AM of the functionality and cleanliness of rooms, secondary to complaints 3047231 and 3029891 the following rooms were observed to have non-functioning dressers, determined by either; dresser drawers on observation hanging open off the tracks, observed from the doorway or drawers were unable to easily be opened, when tested after permission obtained from the resident. A follow-up tour with the facility NHA was completed on 7/22/26 at 10:26 AM. This tour occurred down the halls of unit 2 regarding the surveyors' observations and concerns. He too identified and verbalized the concern for the white dressers in the multiple residents' rooms as follows: 203, 205, 206, 208, 212, 214, 216, 218, 219, 220, 221, 223 and 225.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on multiple observations and interviews with staff, it was determined that the facility failed to keep a safe, sanitary and clean environment for the residents. This was noted on 2 of 3 floors throughout the course of the survey. The findings include: 1. The facility was toured on 7/17/26 at 5:15 AM on the 2nd floor identified multiple concerns for resident safety and comfort starting in the resident lounge area. At the entrance to the immediate right there were 2 white square tiles adjacent to another set of tiles then a rug, none of which were aligned creating an uneven floor further tripping hazards for residents. Continued observations of the lounge area also noted 3 tables of varying heights next to each other. The tables had gray and white patterned tablecloths that had various stains on top of each in varying colors from blue to brown and yellow. There were heavy black dusty flecks and debris found in the corners and under the furniture in the room. At 6:10 AM on 7/17/26, using a white piece of toilet paper this surveyor dampened it with water, then wiped the floor in front of the nursing station, where residents are frequently placed in Geri-chairs. The appearance of the toilet paper after one pass and wipe of the floor was thick dark and black. Tour and observation of room [ROOM NUMBER] was observed at 9:03 AM with food on the floor after breakfast. This surveyor followed up and toured again on 7/17/26 at 10:45 AM and the food was still on the floor in a pile in front of the door. Tour of the facility on 7/22/26 at 6:55 AM of the second-floor unit and lounge revealed the same identified concerns as noted on 7/17/26, including the same tablecloths with the same stains. The floor was also noted sticky; there were cheerios noted under the table observable from the doorway and chip crumbs on the opposite side of the room under the table. Touring down the hallway, there was a pile of chip crumbs and plastic directly in the middle of the doorway outside of room [ROOM NUMBER] and Fritos twists style chips in front of room [ROOM NUMBER]. A single, alone housekeeping cart was then observed when this surveyor returned from touring the ground and 1st floor sitting in front of the lounge at 7:20 AM. Follow up tour at 8:43 AM of the lounge, revealed the same observations, as well as pile of chip crumbs in front of room [ROOM NUMBER] and Fritos twists in front of room [ROOM NUMBER]. A housekeeping staff member # 21, was observed down this same hall by room [ROOM NUMBER] at a stock room putting trash bags in her cart at that time. She was asked if she was the only housekeeper assigned to this floor and she stated 'yes,' and that she starts from one end of the hall and works her way to the other. She was asked if she was only assigned to this floor and she stated 'yes.' (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Tour at 10:20 AM of the lounge on unit 2, noted that the cheerios observed from the doorway were cleaned up, however the chips and crumbs that were present and observable from the other side of the table were still present. Continued tour of the remainder of unit 2 revealed the same observations as completed at 6:55 AM. At 10:26 AM during the 2nd floor tour and observations, the facility NHA approached the surveyor and then was asked by this surveyor to proceed on this tour. The observations noted from 6:55 AM, 8:43 AM and 10:26 AM were reviewed and the presence of the same debris, chips and crumbs from rooms 217, 223 and the lounge all remained and he photographed and documented as well along the way. As this surveyor was showing the NHA the observations in the lounge, including the unlevel floor, a resident who was visibly independently mobile in a wheelchair came into the lounge and then turned right. The tires of the wheelchair became stuck between the uneven tiles and carpet in front of the ice machine with the handwritten sign saying 'broken.' This resident needed assistance to maneuver the tiles and rug, and this was provided by the NHA. On 7/22/26 at 10:50 AM staff #22, the housekeeping supervisor, was interviewed. She was asked about her expectations of her staff and what shifts they work. She stated there are no housekeepers at night. They come in, in the morning and start at one end of the unit and work their way around. The observations just from today and in the 3-hour window of blatant and obvious food and debris being left on the floor at the entrance to resident rooms, in addition to the blackness that was found on the floor. She stated again she doesn't have staff at night. She further stated that everyday the floor is scrubbed using an Auto-Scrubber machine daily. This surveyor asked the floor care process, do they change the pads, how are they ensuring that the floor is actually getting clean? Staff #22 stated that the floor is done 3 times a day and that they can just start wet mopping at the nursing station where the dirty area was found. This surveyor asked if staff #22 was stating that the dirt acquired from the surveyor's observation and test of the wet toilet paper on the floor was just dirt that had acquired from the night shift and she said yes as they do the auto-scrubber after breakfast, after lunch and before dinner. The concern was still not addressed that the Auto-Scrubber being used on the floors is not sufficiently cleaning the entirety of the floors and further using a wet mop just around the nursing station wouldn't correct the problem. The overall concerns were discussed throughout the survey and again during exit on 7/23/26. 2. An observation on 7/28/26 at 8:02 AM of the 1st floor nursing unit revealed straw papers and debris lying on the floor throughout the unit. An observation of a carpeted room with a sign, Caf&eacute; revealed the carpet appeared dirty, there was debris and food crumbs on the floor. A piece of orange candy and a needle lid was lying next to the trashcan in the room. The tan colored blinds were broken on the right side and were visibly grayish colored. The white heating and cooling units below the windows had blackened spots and run marks as if fluid had been spilled and ran down. There was a TV stand that had missing handles on some of the drawers. A second observation of the 1st floor nursing unit on 7/17/26 at 5:25 AM revealed debris and trash on (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the floor throughout the unit. The Caf&eacute; room was in the same condition as described in the 7/15/26 observation as well as a water cup sitting at the computer. During an interview on 7/20/26 at 1:45 PM the Environmental Director Staff #22 reported that staff were on duty between 6:30 AM and 4:00 PM. She stated that after dinner it was the nursing assistant's responsibility to clean the caf&eacute; area. The surveyor and Staff #22 toured the Caf&eacute; on the 1st floor, she was shown the concerns and how the Caf&eacute; continued to be in the same condition with food crumbs and debris on the floor, the broken, dirty blinds, and the dirty heating and cooling units below the windows. She acknowledged the concerns.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on medical record review and interview with facility staff and the review of a facility reported incident (FRI), the facility failed to implement appropriate interventions for the prevention of future occurrences of all types of abuse. This was evident during the review of 1 of 2 facility reported incidents. (Resident #2)The findings include: On 7/17/26 at 6:02 AM a review of the facility's self-reported incident 2746331 regarding an allegation of physical abuse occurring on 2/16/26, perpetrated by nursing aide (Aide) #19 towards Resident #2 was reviewed. This review revealed that as part of the investigation, in-service training was completed for the staff starting on 2/16/26. Closer review of the in-service list revealed that the staff present and interviewed on the shift when the allegation of abuse occurred were not on the list of staff educated for ?Abuse recognizing, reporting and preventing abuse, neglect and exploitation and misappropriation.'The investigation for incident 2746331 was reviewed with the facility DON and NHA on 7/22/26 at 1:2:45 PM. The DON was interviewed on 7/23/26 at 12:30 PM and asked for her expectations on post incident in-service training. She agreed that all staff, especially those potentially involved in the allegation should be involved in any post educational in-service.		

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on medical record review and interview with facility staff, it was determined that the physicians failed to have their notes in the medical record timely after seeing the resident and to have the most accurate resident medical information in the physician notes. This was evident for 2 of 2 residents (Resident #9 and #1) reviewed during a complaint survey. The findings include: 1. Review of the medical record for Resident #9 on 7/16/26 at 12:03 PM revealed that on 4/14/26 Nurse practitioner (NP) #27 visited with Resident #9 and discussed with the power of attorney the plan for a below the knee amputation. Although the note documented that the resident was visited on 4/14, the note was not available on record until 4/18/26. 2. Review of the medical record for Resident #1 on 7/15/26 at 9:31 AM revealed multiple hospitalizations requiring new history and physicals (h and p) on each readmission. A history and physical is a review of the residents' health, medications, care and includes a plan for ongoing care. According to the electronic health records (EHR), on 5/14/26, NP #27 initiated a progress note, the effective date was documented as 5/15/26, however, the note was not available on the EHR until 5/17/26. Further review noted another admission note from NP #27 on 6/23/26, however, it was not signed or available for staff review until 6/25/26. The progress notes completed by the residents attending physician, including history and physicals from 5/17/26-6/24/26 were all initiated and posted after more than 24 hours of seeing the resident and reviewing his/her orders. Further, there was an Attending # 28 note with a date of service initiated on 7/2/26 that was not available until 7/10/26 and a 7/5/26 note, not available until 7/10/26. Additional review of Resident #1's medical record also revealed that a gradual dose reduction (GDR) was completed on his/her Seroquel on admission in the fall of 2025. However, both the NP #27 and Attending #28 documented that Resident #1 remained on the admission dose of Seroquel from August 2025 through January 2026. NP #27 was interviewed on 7/22/26 at 11:28 AM regarding the findings and the delay of the notes entered in the residents' charts. She stated that when she visits the residents, she tries to have the notes published within 48 hours so if there is anything acute it is available. She further stated that she should update the records sooner when she dictates if there is a change as she is aware of the delay in the dictation as it goes out to another country for transcription then by the time it comes back and she reviews, it is about 48 hours. She was then asked specifically about the Seroquel and Resident #1. It was determined through this interview that the psychiatrist would order the medication, the nurse would report the recommendation of the psychiatrist to the NP or physician and then the NP or physician would put the order in the computer. It was further determined that NP #27 was the one who signed off for the Seroquel GDR order in the computer, although in her notes she continued to document that Resident #1 was still on the same dose. The concerns related to the physician documentation and delay was reviewed with the facility DON and NHA throughout the survey and again during exit on 7/23/26.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interview, it was determined that facility staff failed to ensure the resident had a medication error rate of less than 5%. This was evident for 2 (#10 and #11) of 3 residents' observed for medication administration. The findings include: Hypothyroidism - is thyroid hormone deficiency. Symptoms include cold intolerance, fatigue, and weight gain. Signs may include a typical facial appearance, hoarse slow speech, and dry skin. (Merkmanual.com 2026). Levothyroxine (Synthroid) is a medication that acts as the thyroid hormone and is used to treat hypothyroidism (low thyroid levels). (merkmanual.com 2026). Levothyroxine tablets are absorbed better when a resident has been fasting and should be administered 30 - 60 minutes before breakfast. The medication should be given 4-5 hours before administering medications that can interfere/interact with the effectiveness of the medication. One type of medication is a proton pump inhibitor (decreases the secretion of stomach acid) such as pantoprazole (Protonix). (Nursing Drug Handbook 2026). Pantoprazole delayed release capsules can affect the concentration and absorption of other medications. (National Institute of Health). Therefore, it is a standard of practice to give the medication 30 - 60 minutes before administering other medications. 1) On 7/17/26 at 5:54 AM an observation of Registered Nurse (RN) #13 administering medications for Resident #10. During this observation she was observed to administer levothyroxine 50 mcg (micrograms) and pantoprazole delayed release 20 mg (milligrams) at the same time. A medical record review for Resident #10 on 7/23/26 at 10:11 AM revealed a physician note dated 7/12/26 that documented under the assessment and plan the resident had hypothyroidism and was to continue to take levothyroxine on an empty stomach. The physician noted that the last time the resident's thyroid levels were checked was 2/26. Further review of the medical record revealed that the nurse failed to notify the physician of the medication error. RN #13 was interviewed on 7/17/26 at 7:58 AM about the observation and stated that she thought the pantoprazole was supposed to coat the stomach for the levothyroxine. She was not aware that the pantoprazole was not to be given with the levothyroxine because it would affect the absorption of the medication. 2) On 7/17/26 at 6:17 AM RN #13 was observed administering the following medications to Resident #11: pantoprazole delayed release 40 mg, gabapentin 300 mg, carbidopa/levodopa 25 - 100 mg On 7/23/26 at 9:49 AM a medical record review for Resident #11 revealed a visit note dated 7/20/26 by Nurse Practitioner (NP) #27. NP #26 wrote that the resident was taking pantoprazole for management of GERD (gastroesophageal reflux disease a condition in which the gastric juices overflow into the esophagus and cause damage to the lining), the gabapentin was to treat neuropathic pain (chronic discomfort caused by damage to the nervous system), and the carbidopa/levodopa was treating the resident's Parkinson's disease. Further review revealed that the three medications were scheduled for 6:00 AM, however this should have been clarified by the nurse given the standard of practice to give pantoprazole before the other medications. During an interview with RN #13 on 7/17/26 at 7:58 AM she failed to offer a rationale as to why she would have administered these medications together. An interview on 7/22/26 at 11:48 AM with NP #26 revealed that the medications were not intended to be administered at the same time. The concerns were reviewed with the Director of Nursing on 7/23/26 at 12:05 PM and she was informed of the 8% medication error rate.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that facility staff failed to ensure that the resident's medication records were complete (Resident #4 and #7) and failed failed to provide residents with an updated bed hold policy when there was a change in Administration (Resident #1 and #5). This was evident for 4 of 9 medical records reviewed during the complaint survey. The findings include: Neurocheck sheets are a template used by nurses to document a neurological assessment at timed intervals following a fall with possible/actual head injuries. 15 &ndash; minute check sheets are a template used by nursing staff to document what a resident is doing every 15 minutes to show that they were being monitored. (SBARs) -Situation, background, assessment, and resolution tool that nurses use to gather information to give the provider and complete overview of the issue, so they can order the appropriate treatment 1. A electronic medical record (EMR) review for Resident #4 on 7/15/26 at 9:59 AM revealed in the assessment tab there were SBARs that documented the resident had falls on 6/19/26, 6/21/26, and 6/25/26. However, there was no evidence that neurochecks were completed after the falls. 2. An EMR review for Resident #7 on 7/20/26 at 2:25 PM revealed in the assessment tab there were SBARs that documented the resident had falls on 4/26/26 at 6:30 AM and at 12:00 PM, 4/27/26, 5/6/26, 5/18/26, and 5/22/26. However, there was no evidence in the EMR that neurochecks were completed. On 4/30/26 the resident was placed on 15-minute checks however; there was no evidence in the EMR that they were completed. During an interview with Unit Manager (UM) #24 on 7/16/26 at 9:12 AM she reported that the neurocheck sheets and 15-minute check sheets were kept in a notebook at the nurses station. She reported that they were supposed to be uploaded into the EMR under the miscellaneous tab by the Unit Secretary. An interview with the Unit Secretary Staff #30 on 7/16/26 at 8:58 AM revealed that she was unaware that she was supposed to upload the neurocheck sheets and 15-minute check sheets into the EMR. The concerns were reviewed with the Director of Nursing on 7/23/26 at 9:24 AM. She confirmed that the facility did not maintain a paper medical record for the residents. She stated that the Unit Secretary was assigned the responsibility to upload paper documents into the EMR. 3. Resident #1's medical record was reviewed on 10:15 AM on 7/15/26 regarding complaint 3029891. There were concerns regarding not providing an appropriate discharge notice. This review noted that there were 6 bed hold notices given to the residents between 5/7/26 and 7/1/26. However, a closer review noted that on the line for 'Name of Facility's Authorized Agent' the previous Nursing Home (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrators (NHA) name was pre-printed on the form as well as her signature. 4. Resident #5's medical record was reviewed on 11:23 AM on 7/15/26 regarding complaint 3047231. This review revealed that S/he was hospitalized on [DATE] according to progress notes and transfer assessments completed. There was a 'bed-hold' notice uploaded into Resident #5's medical record on 6/16/26, however, there was no date. This record review did reveal that the resident did not return to the facility after this discharge. Additionally noted on the bed hold notice initiated for Resident #5, the 'Name of Facility's Authorized Agent' was entered as the previous Nursing Home Administrators (NHA) pre-printed on the form as well as her signature. The current facility NHA was interviewed on 11:11 AM on 7/15/26 regarding the findings. He reported that he started on 5/18/26 and that the previous NHA was no longer in the building at that point. He also stated that he identified this concern when he came to the facility as well, however, had not yet implemented a new bed hold policy so the previous one with the previous NHA's name on it was still being used. This review also revealed that the bed hold policy's provided to the residents and or their representatives are copies of copies and therefore, the ink/toner has become streaky and smudged and illegible. This was also reviewed as part of the concern related to the bed hold policy administration and was reviewed again during exit on 7/24/26.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, it was determined that facility staff failed to implement an effective infection prevention and control program. This was evident during a medication administration observation and evident during random observations on the nursing units conducted during the complaint survey. The findings include: 1) During a medication administration observation on 7/17/26 at 5:54 AM, Registered Nurse (RN) #13 was observed emptying the trash bag from the medication cart on the long hallway on 1st floor nursing unit. She handled it with her bare hands and took it to the soiled utility room and placed in the trash can. Without sanitizing her hands, she proceeded to the short hallway medication cart and prepared to administer medications. She stopped and signed paperwork from the lab technician and then proceeded down the hallway. She sanitized her hands prior to applying gloves to check a resident's blood sugar via a fingerstick. A continued observation of RN #13 on 7/17/2026 at 6:17 AM revealed she dropped a pill on the floor. She used a napkin to pick up the pill with her bare hands and threw it away. She failed to sanitize her hands as she continued to prepare Resident #11's medications. 2) Observations of 1st floor nursing unit's short hallway on 7/17/26 at 4:31 AM revealed a linen cart sitting outside room [ROOM NUMBER] with a drawsheet draped over the top however, the 2nd and 3rd shelf were exposed to the air. There were bags of linen and trash laid on the floor between rooms [ROOM NUMBERS]. An observation on the 1st floor long hallway on 7/17/26 at 4:39 AM revealed a linen cart with a fitted cover sitting between rooms [ROOM NUMBERS]. The front flap was thrown over the top with briefs laid on top. The linen on the cart was exposed. During an interview with nursing assistant (Aid) #29 on 7/17/26 at 4:40 AM, she was asked about infection prevention and control related to clean linen. She reported that it was to stay covered to protect the linen from germs in the air. When shown the cart she stated she should have kept it covered. When she put the flap back down, it was observed to be frayed and had holes in it. She reported that bags of linen and trash were to be taken directly to the soiled utility room and not laid on the floor. An interview with Licensed Practical Nurse (LPN) #31 on 7/17/26 at 4:44 AM revealed she agreed that the linen cart on the short hall on 1st floor nursing unit was not adequately covered. She reported that they do not have a cart with a fitted cover like the long hallway. She stated that it may be because they have a linen closet in the hallway. The concerns were reviewed with the Director of Nursing on 7/23/26 at 12:11 PM.		