STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215352	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coffman Nursing Home	1304 Pennsylvania Avenue Hagerstown, MD 21742

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, it was determined that the facility failed to provide a home-like environment for residents. This was evident in three of the three hallways reviewed for the environment.The findings include:During an observation on 7/17/2025, at 12:34 PM, in the 200 hallway, six tiles between room [ROOM NUMBER] and the nurses' station were noted to be cracked.Continued observation of the 300-hallway showed that room [ROOM NUMBER] had eight cracked tiles. Additionally, two tiles under the head of the first bed had bubbles, and six tiles to the right had black discoloration. The observation also found that the trim guard was detached from the bathroom door post, and the P-trap under the bathroom sink was rusted in room [ROOM NUMBER].Further observation showed six cracked tiles between rooms [ROOM NUMBERS]. Then, in the 400 hallway, four tiles between rooms [ROOM NUMBERS] were broken.An observation of the unit shower room revealed two cracked tiles behind the door.During an environmental tour on 7/21/25, at 10:14 AM, Staff #5, the Maintenance Director, confirmed all the findings and stated that they would address them.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and staff interviews, it was determined that the facility failed to ensure that Minimum Data Set (MDS) assessments were accurately recorded. This was evident for 1 (#8) of 5 residents reviewed for unnecessary medications and 1 (#40) of 2 residents reviewed for the Preadmission Screening and Resident Review (PASSR) screening.The findings include: The MDS (Minimum Data Set) is a complete assessment of the Resident that provides the facility with the information to develop a care plan, provide the appropriate care and services to the Resident, and modify the care plan based on the Resident's status. MDS assessments must be accurate to ensure that each Resident receives the care they need.Active diagnoses documented on the MDS assessment are attending provider-documented diagnoses in the last 60 days that directly relate to the Resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.1) A review of Resident #8's medical record included an order audit report that showed an attending provider's order for Resident #8 to receive an antipsychotic medicine for mood and behavior, effective 3/14/25. And the diagnosis for the medicine was Dementia with other behavioral disturbance.Further review included MDS assessments for Resident #8 dated 3/26/25 and 6/24/25. The MDSs recorded in section I0020B and I8000A that Resident #8 had an active diagnosis of Dementia without behavioral disturbance.In an interview on 7/22/2025 at 4:28 PM, Staff #13, the MDS Coordinator, reported that she missed it when Resident #8's diagnosis of Dementia was updated with behavioral disturbance. Staff #13 added that she would correct the MDS assessments.2) A review of Resident #40's MDS assessments dated 12/25/24, 3/25/25, and 6/23/25 showed a documentation of Psychotic disorder as one of the Resident's diagnoses in section I. Further review of the record did not reveal supporting documentation for the diagnosis.In an interview with Staff #13, it was indicated that to code an active diagnosis on the MDS assessment, it should have been documented in an attending provider's note within the last 60 days and treated over the previous 7 days preceding the assessment date, including the assessment date itself.However, earlier record review did not show that Resident #40 was treated for Psychotic disorder during the last 7days to the assessment date, and the attending providers' notes for the past 60 days did not show the diagnosis.During a subsequent interview on 7/22/2025 at 4:40 PM, staff #13 confirmed that Resident #40's MDSs dated 12/25/24, 3/25/25, and 6/23/25 were recorded inaccurately and that she would correct them.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interviews and a review of medical records, it was determined that the facility failed to ensure an interdisciplinary team (IDT) care plan meeting was conducted for a resident. This was evident for one Resident (#48) who was reviewed for care planning.The findings include: A care plan guides each resident's care based on their specific needs. Care plans must be created within 7 days of the admission MDS and updated quarterly or as needed.The Minimum Data Set (MDS) assessment is a federally mandated tool used by nursing home staff to gather information on each Resident's strengths and needs. The information collected is used in the Resident's care planning decisions.The facility must have care plans developed and revised by an interdisciplinary team (IDT), including the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the Resident, and the Resident's representative (as practicable). In an interview on 7/15/2025 at 2:50 PM, Resident #48 was asked if s/he participated in his/her care plan meetings and responded that s/he was not aware of any care plan meeting.A review of Resident #48's medical record revealed that s/he had been residing in the facility since June 2025. The review also noted an admission MDS assessment for Resident #48, dated 6/30/25, and completed on 7/1/25. However, the review failed to indicate that a care plan meeting took place following the completion of the MDS assessment.During an interview on 7/22/2025, at 8:01 AM, Staff #4, Social Services Director (SSD), reported that IDT care plan meetings were scheduled for Residents based on their MDS schedules. The SSD stated that she missed scheduling a care plan meeting for Resident #48 because the date for his/her MDS had been changed.Later that day, the SSD reported that a care plan meeting had been scheduled for Resident #48 after the surveyor's intervention.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on review of medical records and complaint 316958, and interviews it was determined that the facility failed to ensure a resident received care in accordance with professional standards of practice. This was found to be evident for one (Resident #23) of five residents reviewed for unnecessary medication.The findings include:1)Review of Resident #23's medical record on 7/17/25 revealed the resident has resided in the facility for more than 8 months. The resident was admitted with an implanted port in place and orders to access the port once a month to complete a flush with saline and heparin (a medication used to prevent blood clots). A port is a medical device that is surgically implanted under the skin that allows health care providers easy access to a vein. A port can be used for access to give medications, intravenous (IV) fluids, blood transfusions or for obtaining blood samples. Flushing the port lowers the risk of clots and blockages. Review of the nursing progress notes revealed that on 2/3/25 a nurse from the pharmacy completed the flush. This note was completed by the facility Nurse (Staff #1).Further review of the medical record revealed that in the beginning of March 2025 the order to flush the port once a month was still in place. However, review of the Licensed Nurse Administration Record (where the nurse's document the medications they administer to the resident) revealed a blank in the area for staff to document the flush when due on 3/3/25 and a notation that the order was discontinued on 3/3/25. Review of corresponding progress notes, completed by Nurse #1 revealed a notation: port flush changed to every 3 months, last flushed on 2/3/25. Further review of the medical record revealed an Implanted Port Infusion Protocol and Orders form, dated 3/3/25, that included orders to flush the port with saline and heparin once every 3 months. Nurse (#1) had signed the form. On 7/17/25 at 2:09 PM an interview with Nurse #1 revealed that an infusion nurse had completed a training with the staff in regard to completing the flush and referenced her note from February. Nurse (#1) went on to report that the nurse who conducted the training had recommended the flush be completed every 3 months rather than every month.No documentation was found to indicate the physician or nurse practitioner were notified of this recommendation when it was made in February. The surveyor discussed the concern with the DON on 7/22/25 at 4:53 PM, that the staff had received education in February but no documentation was found to indicate the physician was notified about the recommendation to change the order until the next month when Nurse #1 identified that the order should have been changed. Since a flush was completed on 2/3/25, and the order was changed in March to every three months then the next flush would be due in May. Further review of the Licensed Nurse Administration Record revealed a flush was completed on 4/3/25, which was a month before it was due.On 7/17/25 further review of the Licensed Nurse Administration Record revealed a current order was in place to complete the flush once every three months and that it was due to be administered on 7/3/25. In the area to document administration the nurse (Staff #9) documented a 9 which indicates Other/See Progress Notes.There was a corresponding progress note written by Nurse #9 on 7/3/25 at 11:28 PM. Review of this note revealed the nurse had attempted to access the port with the needle, but the needle would not fully access, there was no blood return and was unable to flush. The note also documented that the on-call nurse was made aware and that the night shift nurse had also attempted.Further review of the progress notes revealed a note completed by Nurse #10 on 7/3/25 at 11:44 PM. This note revealed the following: This RN attempted access without results. Resident screaming and waving [his/her] arms during access attempt. Attempts and educating resident and talking with resident were without results. DSD [dry sterile dressing] applied.On 7/17/25 further review of the medical record failed to reveal documentation to indicate the port flush was completed after the unsuccessful attempts on 7/3/25. No documentation was found to indicate the physician or nurse practitioner was notified that the nursing staff was unable to complete the flush as ordered.On 7/17/25 at 11:20 AM Nurse (Staff #12) reported she was aware the resident has a port and that staff flush it, but she was unsure how often and stated that she had never completed the flush. The surveyor then reviewed the concern that the record review revealed the flush was due on 7/3 but that progress notes indicated nursing staff could not access the port, no documentation was found to indicate any follow up or if the port has been flushed in the two weeks since. Nurse #12 stated: the doctor should have been notified.On 7/17/25 at 12:15 PM the surveyor informed the Director of Nursing (DON) that no documentation was found to indicate the port was flushed since it was due on 7/3/25. The DON indicated she would check if there was any documentation to indicate the port was flushed.On 7/17/2025 at 12:28 PM the DON confirmed there was no documentation to indicate the port was flushed or that the physician or nurse practitioner was notified. DON reported she was going to have staff

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview it was determined that the facility failed to maintain the daily posted staffing information in a readily accessible format. This practice has the potential to affect all residents.The findings include:On 7/23/25 at 12:38 PM observation on the nursing unit, with the Director of Nursing (DON), revealed staffing information posted on a large white wipe board for the current day shift. The information on the wipe board included the number of hours worked for registered nurses, licensed practical nurses, certified nurse aides (including geriatric nursing assistants and certified medicine aides) and the current resident census. There was separate paper documentation, also posted, that included the specific staff room assignments but failed to include the actual hours worked for nurses and aides. Surveyor then reviewed the concern with the DON that the posting of the actual hours worked is only on the wipe board and that the regulation requires this information to be readily available and kept for 18 months. DON reported the hours worked information was kept on other reports, not on the saved posted assignment sheets.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on medical record review and interviews it was determined that the facility failed to ensure the residents were free from unnecessary antibiotics. This was found to be evident for one (Resident #54) out of five residents reviewed for unnecessary medications.The findings include:Review of Resident #54's medical record revealed the resident has resided at the facility for more than one year. Review of the primary physician (Staff #16) progress note, signed on 5/16/25 at 10:30 AM revealed the resident was seen that day for a sick visit, patient had a cough with phlegm and that he was waiting on chest x-ray results. The physician assessed the resident as having bronchitis and possible pneumonia. The plan included: Will start Levaquin 500 mg p.o.[by mouth] daily for 7 days; Waiting for chest x-ray if antibiotic needs to be changed; [Discussed] with staff continue to monitor closely.Review of the chest x-ray results, dated 5/16/25 at 4:25 PM, revealed: No active cardiopulmonary disease.Review of the May 2025 Medication Administration Record (MAR) revealed the resident received 500 mg of levofloxacin (also known as Levaquin) for 10 days from May 16 through May 25. The first dose was administered on 5/16/25 at 9:00 PM.On 7/22/25 at approximately 4:15 PM an interview was conducted, in the presence of the infection preventionist nurse (Staff #11), with physician #16. Surveyor requested clarification regarding the Waiting for chest x-ray if antibiotic needs to be changed statement in the 5/16/25 progress note. The physician reported that if the resident had pneumonia then he would have extended the treatment or ordered IV [intravenous] antibiotics. The physician reported that he talks to the nursing staff and gives verbal orders which the nurses then put into the medical record. When asked about the discrepancy of the number of days for the antibiotic treatment, the physician said he thinks it was a misunderstanding. The physician went on to confirm that the order for the antibiotic should have been for 7 days.Antibiotic Stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. This can be accomplished through improving antibiotic prescribing, administration, and management practices thus reducing inappropriate use to ensure that residents receive the right antibiotic for the right indication, dose, and duration. Review of the facility's Antibiotic Stewardship policies revealed they were last revised in December 2016. On 7/23/25 at 3:15 PM the surveyor reviewed with the Director of Nursing the concern related to the administration of an antibiotic for 10 days rather than for 7 days.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and staff interviews, it was determined that the facility failed to ensure that drugs and biologicals were stored in areas that are secure against unauthorized access. This was evident in 2 (the 200 hall and the 300 hall) out of 3 rooms being used to store medications, as observed during the completion of the medication storage and labeling task for the annual recertification survey.The findings include:On 7/18/25 at 11:08 AM, the clean utility supply room located at the end of the 300 hall was observed to be unlocked and accessible. The room contained over the counter (OTC) medications and biologicals, including, but not limited to: vitamin A&D ointment, saline enemas, iodoform packing strips, hydrogel wound dressing, calcium alginate dressings, Silvasorb (Silvadene) for wound care, COVID-19 test kits, razors, and direct care supplies.At 11:28 AM, Nurse #1, was observed in the hallway and was asked whether the door to the clean utility room was normally secured. Nurse #1 stated they did not have a key to the door and further stated, The other clean utility closet does not stay locked, referring to the clean utility room on 200 hall, and then demonstrated that the door to the clean utility room on 200 hall opened freely and was not equipped with a lock or keypad where similar OTC medications and biologicals were stored with direct care supplies. At 11:47 AM, a handwritten sign was observed taped to the 300 hall clean utility room door stating, See the nurse for the key. The 200 hall clean utility room door remained open and accessible.On 7/18/25 at 1:35 PM, during an interview with the Director of Nursing, she was informed of the observations on the 200 hall and 300 hall and acknowledged the deficiency.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a record review, observations, and interviews, it was determined that the facility failed to serve residents meals according to a predetermined menu that reflected their preferences. This was evident in four out of four dining observations during the survey.The findings include:1) A review of the facility's food committee meeting notes was done. The notes revealed that the residents voiced concerns and grievances, including the dietary staff consistently not serving their meals according to their preferences on the meal tickets.A dining observation on 7/17/2025 at 5:35 PM, in the 300 Hall, showed Resident #56 eating dinner in the room. On the Resident's meal tray was a ticket that listed all the food items to be on the tray: sloppy joe on Bun, xplain potato chips, steamed corn, salt and pepper, chocolate pudding, 2% milk, Ice water, vanilla ice cream. However, continued observation failed to show that Resident #56's tray contained vanilla ice cream, salt, and pepper. The Resident's Representative was present and said, We don't always get everything on the ticket. 2) An observation of dinner in the 300 Hallway included Resident #11, eating dinner in his/her room. The observation noted from the Resident's meal ticket was that s/he was to receive a red inner lip plate, a sloppy joe on a bun, mashed potatoes, cream-style corn, salt and pepper, chocolate pudding, ice water, cranberry juice, chocolate ice cream, 2% milk, and low-fat yogurt.However, the observation failed to show that Resident #11 received milk and low-fat vanilla yogurt on his/her tray. The resident stated that s/he did not receive milk or yogurt and added that s/he had requested cottage cheese with his/her meals but did not receive it at times.In an interview on 7/17/2025 at 6:05 PM, staff #17, a dietary aid, confirmed concerns about missing food items on the trays for Residents #56 and #11. And added that missing food items on the residents' trays were dependent on which dietary staff member loaded the meal cart.3) An observation of breakfast on 7/18/2025 at 8:00 AM showed that Resident #40 was eating breakfast in the room. The resident's tray contained corn flakes, scrambled eggs, hash brown patty, special cup, special spoon and fork, special yellow plate, dry wheat toast, butter, salt and pepper, grape jelly, creamer, cranberry juice, 2% milk, coffee, and Prune juice. However, the Resident's meal ticket listed the following items: corn flakes, scrambled eggs, hash brown patty, [NAME] anti-spill cup, small built-up utensils, yellow-lipped plate, dry wheat toast, butter, salt and pepper, grape jelly, creamer, cranberry juice, 2% milk, coffee, Prune juice, and banana. The Resident stated, They missed my banana.4) While observing the dinner tray line on 7/22/2025 at 5:15 PM, the surveyor requested a test tray. The tray contained a meal ticket for Resident #52, which listed the following food items to be served: Manicott Alfredo, Spinach with garlic butter, Wheat roll, butter, salt, pepper, chocolate pudding, 2% milk, Ice water, and a Chocolate ice cream cup.However, continued observation failed to show that Resident #52's tray contained chocolate pudding. The dietary manager was present and was made aware of the concern that Resident #52's tray did not contain chocolate pudding, and he confirmed the concern.In an interview on 7/23/2025, at 11:12 AM, the dietary manager confirmed the concerns and verbalized understanding.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on record review, interviews, and observations, it was determined that the facility failed to ensure that meals were delivered to residents at an appropriate and palatable temperature. This deficient practice has the potential to affect all residents who receive meals from the facility's kitchen. The findings include:A review of complaint #316959 contained a statement that, “The meals are cold and half-cooked”. A subsequent review of the facility's food committee meeting notes revealed that residents had voiced concerns about the presentation, taste, and temperature of foods. A review of the food service temperature logs was completed. The review failed to show food service line temperature records for dinner on 3/6/25, breakfast, lunch, and dinner on 3/13/25, dinner on 3/20/25, dinner on 3/27/25, lunch and dinner on 5/1/25, dinner on 5/20/25, dinner on 5/21/25, dinner on 6/14/25, dinner on 6/15/25, dinner on 6/16/25, and dinner on 6/18/25. The review also revealed two undated food temperature log forms, which also lacked records of food temperatures for lunch and dinner. Continued review of the food temperature policy showed a statement: “Foods will be served at proper temperature to ensure food safety. If temperatures are not at acceptable levels and cannot be corrected in time for meal service, make an appropriate menu substitution and [discard] out-of-temperature range foods. ” However, earlier log reviews failed to show that the required food temperatures were consistently obtained before serving residents. During an interview on 7/15/2025, Resident #1 reported, “The food is always cold.” The resident also added that the liners, which were to be placed between the plates holding the food and the plastic covers to keep the food warm, were rarely present. During a meal observation on 7/17/2025, another Resident, #56, reported that the food was served cold. While observing the dinner tray line on 7/22/2025, at 5:15 PM, the surveyor requested a test tray. The tray contained Manicott Alfredo, Spinach, Wheat roll, butter, salt, pepper, vanilla pudding, 2% milk, Ice water, and Chocolate ice cream. The dietary manager was present and obtained the food temperatures, which showed 57 degrees for the milk. Staff indicated that the acceptable temperature range for the milk should have been less than 41 degrees and verbalized understanding of the concern. In a subsequent interview, the dietary manager reported that to address the concerns about food temperatures, he had ordered additional food liners for the food warming systems. However, his department had just been fully staffed, and he had yet to train them to use the liners. On 7/23/2025 at 12:30 PM, the Nursing Home administrator was informed of the food concerns and verbalized understanding.

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a record review, observation, and interviews, it was determined that the facility failed to provide an assistive device for eating to a Resident. This was evident in one of four dining observations during the survey.The findings include:On 7/15/25, at 8:14 AM, a review of a report provided by the dietary manager for Residents who require special utensils during meals was completed. The review showed that Resident #40 required “a [NAME] anti-spill cup, a yellow-lipped plate, and small built-up utensils [special fork and spoon with built-up handles to aid people with a weakened grip]” for every meal. However, during dinner observation on 7/17/25, at 5:35 PM, Resident #40 was eating dinner in his/her room and did not have his/her weighted utensils. Staff #6, a geriatric nurse aid, was present and stated that she had given Resident #40 regular utensils because the weighted utensils had not been received from the dietary staff. In an interview on 7/17/25 at 6:05 PM, Staff #17, a dietary aid, confirmed that Resident #40 did not receive his/her weighted utensils on the meal tray and stated that she would notify her supervisor of the concern. During an interview on 7/21/2025 at 8:11 AM, Staff #19, an occupational therapist, reported that Resident #40’s weighted utensils were to help limit spillage and gather food during meals due to decreased fine motor strength and coordination. However, earlier observations failed to show that staff provided utensils to the resident during mealtime.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215352	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coffman Nursing Home	1304 Pennsylvania Avenue Hagerstown, MD 21742

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, it was determined that the facility failed to store and prepare food in accordance with professional standards and guidelines. This deficient practice has the potential to affect all residents.The findings include:An observation of the facility's walk-in refrigerator on 7/15/25, at 8:14 AM, with staff #18, the dietary manager, present, revealed nine cabbages with a grayish substance growing on them. He indicated that the cabbages had gone bad and discarded them.Continued observation revealed a bag of broccoli with a label stating, Best if used by 7/8/25. Staff confirmed that it had expired and removed it for disposal.Further observation noted a bag of shredded cheese with an open date of 7/14/25 but had no use by date.The observation also showed an opened and halfway used [NAME] buttermilk ranch dressing labelled with a received date of 3/20/25. However, the label did not indicate the open or use-by date.An observation of the facility's walk-in freezer revealed a container of prepared spaghetti sauce with a date of preparation listed as 5/29/25. It did not have a use-by date. Staff #18 said it should have been used within 4 weeks and took it out to discard. He also said he was aware of the labeling issues, so he had initiated a Performance Improvement Plan (PIP) to address this issue.A subsequent observation of the nutrition room refrigerator on the nursing unit with staff #20, a licensed practical nurse, showed a carton of thickened orange juice with a use-by date of 4/30/25. Staff #20 indicated it had expired and discarded it after the surveyor's intervention. She also noted that the dietary staff were responsible for stocking and disposing of expired food items from the nutrition room refrigerator.In an interview on 7/21/25 at 2:48 PM, Staff #21, the Culinary Operations Manager, said she had provided training to the dietary staff regarding labeling, dating, and rotating perishable food items after the surveyor's intervention.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, review of policies and medical records, and interviews it was determined that the facility failed to ensure staff maintained standard and enhanced barrier precautions (EBP) while providing care; and failed to ensure the infection prevention and control policies and procedures were reviewed and revised at least annually. This was found to be evident for 3 (Resident # 3, #37 and #29) out of 40 residents included in the sample.The findings include: 1a) An observation made on 7/16/2025 at 9:31 AM noted a sign outside Resident #3's room that indicated that the Resident was on EBP and required staff to wear gowns and gloves during high-contact care activities. Enhanced Barrier Precautions (EBP) are infection control measures designed to reduce the transmission of infections in healthcare settings, including nursing homes. EBP involves wearing gowns and gloves during high-contact care such as dressing, bathing, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting for residents with infections, MDRO colonization, indwelling devices, or wounds. A review of Resident #3's record showed that s/he was on EBP due to having a wound. The review also included an EBP care plan for Resident #3. The care plan had recorded that “Staff will don[wear] gown and gloves for all high contact Resident care activities”. However, during a subsequent observation of morning care for Resident #3, staff #6 and #7, both geriatric nurse aids (GNAs), wore gloves but did not wear gowns, despite the posted EBP requirements. In an interview on 7/16/25 at 9:50 AM, both GNA #6 and #7 stated that Resident #3 did not have a wound and therefore were not required to wear a gown during high-contact resident care. Both staff members confirmed seeing the EBP signage outside the resident's room, but indicated it needed to be removed because Resident #3 did not have a wound. A subsequent interview on 7/17/2025 at 11:18 AM, with staff #8, a licensed practical nurse, revealed that Resident #3 had a wound that required daily treatment, and staff needed to gown up before providing high-contact resident care. In an interview on 7/17/2025 at 11:59 AM, Staff #11, the infection preventionist (IP) nurse, indicated that she was made aware of the concern regarding not wearing a gown before providing high-contact care to Resident #3. The IP nurse indicated that steps would be taken to address the concern. 1b) Review of Resident #37's medical record on 7/15/25, revealed the presence of a stage 3 pressure ulcer on the resident's heel. A Stage 3 pressure ulcer indicates there is full thickness skin loss. Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are indicated for residents with pressure ulcers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/17/25 at 9:59 AM the surveyor arrived at the resident's room and observed Nurse (Staff #1) completing Resident #37's dressing change. There was a sign posted outside of the resident's room indicating Enhanced Barrier Precautions were in place for this resident. The nurse had already removed the old dressing and was in the process of cleaning the wound when surveyor arrived for the observation. Surveyor noted that Nurse #1 was not wearing a protective gown while completing the dressing change. On 7/17/2025 at 10:13 AM, after the dressing change was complete, the surveyor asked Nurse #1 what was her understanding of EBP? The nurse responded she was not 100 % sure, indicated the infection control nurse would know more and then stated: “I was suppose to wear a gown, wasn't I?” On 7/17/25 at 11:59 AM the Infection Preventionist (IP) Nurse (Staff #11) reported that EBP was reviewed with the staff within the last month or two. The Infection Preventionist Nurse confirmed that any resident with a pressure ulcer would require the use of gown and gloves during high contact care. The Surveyor then reviewed the observation from this morning of the nurse performing a dressing change without wearing a gown. 1c) On 7/17/25 at 08:16 AM, during the observation of medication administration with Nurse#1 for Resident #29, Nurse #1 was observed preparing and priming an intravenous (IV) line and pump without donning gloves. Nurse #1 handled the IV equipment and tubing without adherence to standard infection control precautions. On 7/21/25 at 4:09 PM, an interview was conducted with the Director of Nursing (DON) regarding the facility's infection prevention and control policies and the facility's annual review process. The DON stated that there was no evidence the infection prevention and control program had been reviewed in the past year, and no documentation could be provided to demonstrate that policies, procedures, and standards had been evaluated or revised based upon the current facility assessment or resident population. The policies presented were generalized, templated forms with dates ranging from 2017 to 2023 and lacked facility-specific identifiers based on the facility assessment. On 7/23/25 at 12:47 PM, the DON confirmed again that the facility was unable to provide evidence that a review or revision of the infection prevention and control policies had occurred to ensure alignment with current standards or the facility's specific assessment.