STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235379	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Tawas City	400 North Street West Tawas City, MI 48763

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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 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 interview and record review, the facility failed to ensure that two residents (Resident #9 and Resident #72) were adequately supervised to prevent falls out of 5 residents reviewed for falls, resulting in the likelihood of a fear of falling, skin tears, head injuries with hospitalization and repeated individual falls. Resident #9: Record review of the facility provided CMS-802 'Resident Matrix' identified Resident #9 as had a fall with injury. An observation and interview on 09/10/2025 at 10:19 AM with Resident #9 revealed that she was laying on the top of her bed with the room partition/privacy curtain pulled so that the resident could not be observed from the doorway of the room. Resident #9 stated that she did have a fall at her closet but could not recall when the fall had occurred. Resident #9 stated that she did have a broken arm from the fall and tailbone pain. identified a fall with major injury and resident stated that she had a fall at her closet. In an observation on 09/11/2025 at 10:34 AM, Resident #9 was noted to be lying in bed with the room partition curtain pulled between beds and the resident was not able to be seen from the hallway. Resident #9's legs and feet are off the bed, and she has taken her shoes off with no grippy socks noted. Shoes at bedside. Observation on 09/12/2025 at 10:36 AM- resident observed up in activity sitting outside in the sun on back patio area with 6 other residents and a volunteer. Resident appears a sleep and leaning to the left of WC. An interview and record review was conducted on 09/12/2025 at 11:30 AM with the Director of Nursing regarding Resident #9's repeat falls: Fall on 3/4/2025 fall with Fractured wrist and pelvis. Record review of Resident #9's 'Un-witnessed Fall' form dated 3/4/2025 at 5:45PM the Resident #9 was found on the floor by CNA in resident room. Resident #9 was then Hoyer-lifted off the floor. pain was noted, 2 days later she was sent to the ER hospital- x-rays of fractured wrist and pelvis. The state surveyor asked if the incident was reported to the state as it was an unwitnessed fall. DON did not know and referred the surveyor to the Nursing Home administrator. Observed on Floor fall on 4/22/2025 at 7:50PM Resident #9 was found on the floor in her room between her bed and wheelchair. (continued on next page)

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	Observed on Floor fall on 7/4/2025 at 00:20AM resident was observed to be lying on the floor on her stomach with a left side of her head resting on the floor with a laceration. Resident was not wearing any footwear. Resident complained of being very dizzy and did not feel good Sent to emergency room to be evaluated. Resident #9 received 2 sutures to the scalp laceration Record review of Resident #9's Care Plans pages 1-36 for updated fall interventions with the Director of Nursing revealed that there were no new interventions added to the fall/injury care plan after the 7/4/2025 fall with laceration to the head. Record review of Resident #9's 'Emergency Department provider Notes dated 3/6/2025 revealed: [AGE] year-old female who was sent in from her nursing home for treatment of a distal radius fracture on the left. Approximately 2 days ago the patient had a slip and fall at the facility and was having left shoulder and wrist discomfort there is bruising on the wrist and hand. they did x-ray and it showed a commuted fracture of the distal metaphysis of the radius, so they sent her in. In the Emergency Department she is also complaining of pain in the hand and also thinks her fingers might be broken as well, and she is also complaining of pain in the tailbone. CT scan exam revealed mildly displaced fracture of the right superior pubic ramus, mildly displaced fracture of the inferior pubic ramus on the left. In an interview on 09/12/2025 at 12:43 PM with the Nursing Home Administrator in regard to Resident #9's fall with fractures revealed that the facility did not report/turn in the fall with fractures (wrist/Pelvis) because the resident was her own person and she told the facility what happened. Resident #70: Record review of the facility provided CMS-802 'Resident Matrix' identified Resident #9 as had a fall with injury. Observation and interview on 09/10/2025 at 12:22 PM with Resident #70 revealed him to be lying in bed in the dark. Resident #70 was awake and complained of headache. Resident #70 stated that He did have a fall but could not state if it happened in the resident room but that his head got sewed up. Record review of Resident #70's 3-month fall/incident report look back revealed fall had occurred. Fall on 6/2/2025 at 8:45AM was a witnessed fall resulting in laceration to the head from fall off the bed with certified nurse assistant in the room. Fall resulted in laceration to the head and right elbow skin tear. Miami-J collar applied at the facility and sent to the hospital due to use of daily blood thinners with possible head injury. Fall on 6/4/2025 at 2:45PM un-witnessed fall in resident's room. Found on floor next to bed and the wheelchair next to him. No injury noted. Fall on 7/8/2025 at 1:55AM un-witnessed fall resulting in laceration to the head. Upon assessment staff noticed a puddle of blood, went and pulled the call light out of the wall to get assistance and grabbed some wet towels and applied pressure to his right eyebrow to help stop the bleeding. sent to emergency room for sutures to close laceration. Fall on 8/12/2025 at 5:50PM witnessed fall of resident toppled forward of the bed and hit his forehead. Fall report noted resident was getting up for meal and was observed to be lying on his back (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	and crying that he had fallen and his forehead hurt. Root cause: sitting on edge of bed unattended. In an interview and record review on 09/12/2025 at 11:44 AM with the Director of Nursing (DON) regarding Resident #70's repeat falls with head injuries and blood thinner usage. The fall/injury related to generalized weakness, Lennox-Gastaut Syndrome, Cervical fracture and myelopathy car plan was reviewed with the DON. The DON acknowledged that there could be more interventions for prevention of falls. Resident #72: Review of Face Sheet, care plans dated 1/24, and Minimum Data Set (MDS), revealed Resident #72 was [AGE] years old, admitted to the facility on [DATE], was extremely confused with staff assistance required for all Activities of Daily Living/ADL's and had a history prior to admission and at the facility of falls. The residents diagnosis included, Dementia, stroke, malnutrition, depression, cognitive communication deficit, unsteadiness on feet, muscle weakness, and repeated falls (at home and facility). Observation was made on 9/10/25 at 12:40 p.m., of the resident on the Homestead Unit (Dementia unit) sitting in the day room. She had a thick crust of dried blood over her left eyebrow approximately 1 inch in length. The resident was unable to be interviewed due to decreased cognition and communication deficit. Review of the residents facility care plans dated 1/24, revealed she was unsteady, required one staff assist for all transfers and observation when in wheelchair, staff were to supervise closely with increased anxiety, and said she was impulsive and had a history of falls. Review of the facility nursing notes dated 8/14/25, stated Resident had witnessed fall in homestead dining area. She was running and tripped over her feet. Skin tear noted to left eyebrow, left side of nose, and left middle finger. Review of Hospital records dated 8/14/25, stated [AGE] year-old female with a history of dementia presents to the emergency department (ED) by ambulance for a fall, patient fell out of her wheelchair at the nursing home. The ED treated an abrasion to bridge of nose and laceration repair to left eyebrow area. During an interview done on 9/12/25 at 9:22 a.m., Nursing Assistant/CNA P stated She is not supposed to get up, we just keep a close eye on her. She does walk and run but now she is unsteady so we keep a close eye on her. We usually have 3 CNA's and a nurse on days. Review of Resident #72's Prior Fall's at Facility per Nursing Notes and Incident/Accident Reports: -On 12/23/24: Resident was running down hall and tripped and fell. The resident received a head injury from fall. Resident was sitting with another resident when they said something that upset her and she started to get anxious and pace back and forth down the hallway, she ran then went to sit back down and back up and started running down the hallway and tripped and fell and hit the left side of her face. This fall resulted in a head injury. -On 3/20/24: Resident was witnessed bending over to pick up crumb on floor and slowly leaned forward and fell, was laying near frig on left side. Bump on left side of head. She had been pacing in (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	hall after dinner. This fall resulted in skin tear to left elbow and she hit her head. -On 4/14/25: Resident was sitting in dining area in a chair and slipped out of chair onto the floor, no injuries occurred with this fall. -On 5/7/25: Resident was standing in the dining area with other peers and staff when I looked away to check the computer and I heard a thud. I looked over and (Resident #72) is on the floor. Her back and head hit the floor the door when she fell. The resident had just had a shower and was standing in the day room; she had weakness after her shower. The resident hit her head on the door and floor. -On 6/5/25: Resident ambulating in hall when staff member noted resident was on buttocks in hallway. -On 6/8/25: Called to residents room, resident observed laying on her back next to her bed-CNA (Nursing Assistant) was behind her. CNA caught resident upper torso and managed to lower her to floor-resident was incontinent of bowel at the time of fall. -On 7/17/25: The resident was self-propelling in w/c (wheelchair) and then stood up while catching her pant pockets on the w/c causing her to lose her balance and fall to the floor. During an interview done on 9/12/25 at 8:55 a.m., CNA P stated We are to keep an eye on her, she gets upset and gets out of her wheelchair and runs. During an interview done on 9/12/25 at 9:00 a.m., Activity Aide Q stated She can get up and run, when ever she feels like she has the erg, she gets up and runs. She has had quite a few falls, we all just try to keep an eye on her. During an interview done on 9/12/25 at 9:32 a.m., Nurse, RN B stated She gets agitated and gets up and runs, if you tell her no, she gets agitated. She bangs on windows, and runs. Yes, she has had a lot of falls. The unpredictability of her response. We need to distract her when she is agitated. During an interview done on 9/12/25 at 9:37 a.m., CNA R stated She does get up in run, we sit with her and do one-on-one with her. We can tell when she starts getting agitated, she starts mumbling, her hands and fingers start going, and she tries getting up. During an interview done on 9/12/25 at 9:56 a.m., Infection Control/Nurse Manager, RN C stated We do have a fall/IDT committee, we have clinical daily, new behaviors, and falls and monthly (are reviewed by committee). I was in the dining area passing pills (regarding the fall on 8/14/25), I was looking at the computer and I heard the staff member say slow down [NAME] and then she fell in the dining room between two tables, she can get going pretty fast. We just need to come up a better plan of care. During an interview done on 9/11/25 at 11:26 a.m., the Director of Nursing/DON stated yes, there is an issue (with residents repeated falls at the facility), but she is impulsive; that's why her (Family Member) put her here. The DON said the facility was aware of the residents impulsiveness, increased anxiety when she gets upset and repeated falls. Review of the Facility Fall policy dated 11/2/2023, stated As part of an initial and ongoing resident assessment, the staff will help identify individuals with a history of falls and risk factors for (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	subsequent falling. Based on the assessment an initial plan of care will be developed and implemented to address identified risks. This will be revised as necessary. If the individual continues to fall, the interdisciplinary team should re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions. Post fall analysis items to be considered (not all inclusive): The nurses notes Review for med changes in the last 30 – 90 days Review previous lab findings Review for other acute clinical changes Review staff and witness statements (to include last time resident seen, provided care, and what type of care) Review of care plan and CNA assignments/Kardex that were in place at time of fall Observe any equipment involved (i.e. wheelchair, bed, commode, shower chair, etc.) Observations of the resident's room or area of fall Reenactment

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement and operationalize a comprehensive infection control program, encompassing accurate outcome and process surveillance, accurate data collection/documentation/analysis, failure to ensure readily accessible hand hygiene supplies/equipment, and appropriate use of Personal Protective Equipment (PPE) for transmission-based isolation precautions, resulting in a lack of accurate and comprehensive infection control tracking, surveillance and data monitoring/analysis, a lack of hand hygiene completion, PPE use, and the likelihood for the spread of microorganisms and illness to all 73 facility residents.Findings include: Transmission Based Precautions (TBP) Resident #1 On 9/10/25 10:06 AM, a sign was noted outside of Resident #1's room specifying the Resident had Enhanced Barrier Precautions (EBP) in place. CNA T was asked why Resident #1 had EBP and replied, Has tube feeding. CNA T was observed entering the Resident's room. Resident #1 was awake in bed and their pants and bedding were visibly saturated with urine. CNA T began providing care and assisting the Resident while only wearing gloves. Med Tech CNA L entered the room wearing a gown, gloves, and mask as CNA T was assisting Resident #1 to the bathroom and told CNA T to go help a different resident. Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses which included cerebral palsy, Angelman syndrome (genetic disorder that affects the nervous system and causes development delays, intellectual disabilities, problems with movement, and speech impairment), epilepsy, and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) assessment revealed the Resident was rarely/never understood and dependent upon staff to complete Activities of Daily Living (ADLs). The MDS further detailed Resident #1 had a feeding tube. Review of Resident #1's Electronic Medical Record (EMR) revealed a care plan entitled, Resident requires enhanced barrier precautions related to PEG (Initiated and Revised: 7/30/25). The care plan included the interventions: - Use gown and gloves when providing direct care. Face protection may be needed if performing activity with risk of splash or spray (Initiated: 7/30/25) - Utilize Enhanced Barrier Precautions when providing high contact resident care activities (dressing, bathing, transferring, personal hygiene, changing linens, changing briefs/assisting with toileting, device care: central lines, urinary catheters, feeding tubes, tracheostomy/ventilators, wound care, dialysis) (Initiated: 7/30/25) Resident #2 On 9/10/25 at 10:14 AM, A Contact Precaution sign was observed on Resident #2's room door. Activity Aide S was observed in the hallway near the Resident's room. When asked if they knew the why Resident #2 had Contact Precautions in place, Activity Aide S stated, No. Certified Nursing Assistant (CNA) T was observed walking down the hall and was asked if they knew why Resident #2 had contact precautions in place and replied, (Resident #2) has a central line (PICC). When asked if the Resident had an infection, CNA T replied, No. When queried why a different resident (Resident #1) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	who residing on the hallway had Enhanced Barrier Precautions (EBP) in place, CNA T replied, (Resident #1 has a PEG (Percutaneous Endoscopic Gastrostomy- surgically created hole in the abdomen wall to the stomach in which a tube is placed for to allow for the introduction of nutrition) tube. CNA T was asked to explain why Resident #2 was on Contact Precautions because they had a central line but no infection when Resident #1 was on EBP because they had a PEG tube and replied, I don't know. When queried what Personal Protective Equipment (PPE) is required to be worn by staff to enter Resident #2's room, CNA T revealed they wear PPE when touching the Resident but not if I just go in to grab something. An interview was completed with Resident #2 in their room on 9/11/25 at 8:20 AM. When asked if all facility staff wear PPE when they enter their room, Resident #2 replied, Not all. Record review revealed Resident #2 was most recently admitted to the facility on [DATE] with diagnoses which included infection, rheumatoid arthritis (RA), Post Traumatic Stress Disorder (PTSD), and Chronic Obstructive Pulmonary Disease (COPD). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required set-up to substantial assistance to complete all Activities of Daily Living (ADLs). Review of Resident #2's Electronic Medical Record (EMR) revealed a care plan entitled, Resident has an infection as evidenced by MRSA (Methicillin-Resistant Staphylococcus Aureus – antibiotic resistant bacteria) Right Shoulder Abscess. Right Arm skin deficit. IV (intravenous) ABT (antibiotics) (Initiated: and Revised: 8/18/25). The care plan included the interventions: - Contact isolation precautions (Initiated: 8/15/25) - Review with resident the importance of good hand hygiene; assist as needed (Initiated: 8/15/25) Hand Hygiene Supplies/Completion On 9/10/25 at 9:59 AM, the hand sanitizer dispensers on the D Hallway of the facility were all observed to be empty. On 9/10/25 at 11:45 AM, the hand sanitizer dispensers on the B Hallway of the facility were all observed to be empty. On 9/10/25 at 12:00 PM, Central Supply Staff X was asked who the Infection Control (IC) nurse was and indicated they would get Registered Nurse (RN) D. An interview was completed with Nurse Educator Registered Nurse (RN) D on 9/10/25 at 12:10 PM. When queried regarding the hand sanitizer dispensers in the hallways not having any sanitizer in them, RN D confirmed the dispensers were empty and stated the hand sanitizer had been recalled. When queried if staff were provided with individual hand sanitizers to keep on their persons, RN D replied, No, did not give staff hand sanitizers. With further inquiry, RN D stated, They (staff) are supposed to wash their hands in resident rooms. When asked if the sink in resident rooms was in the bathroom which was shared by two rooms, RN D confirmed. When asked how staff are supposed to wash their hands if another resident is using the shared restroom and hand sanitizer was not provided to them by the facility, RN D did not provide an explanation. RN D then stated, There is a container in my office. When asked if their office is readily accessible to all staff working throughout the building 24 hours a day, RN D did not provide a response. With further inquiry regarding the hand sanitizer (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	recall, RN D revealed Staff X would know more as they are in charge of ordering supplies. With additional discussion, RN D revealed they are no longer the IC Nurse for the facility and are now the Nurse Educator. RN D stated RN C was now the IC Nurse. An interview was completed with Central Supply Staff X on 9/10/25 at 12:15 PM. When queried regarding the hand sanitizer recall, Central Supply Staff X revealed multiple products produced by the company had been recalled due to bacterial contamination. Central Supply Staff X stated the facility switched from Purell brand sanitizer to the brand that had been recalled due to cost but were in the process of switching back to Purell. Central Supply Staff X was asked if the facility ordered and/or provided personal hand sanitizer dispensers for each staff member due to the hand sanitizer being removed from the building and replied, No. Central Supply Staff X then stated, I did order 48 four-ounce (oz) bottles of hand sanitizer but revealed the product had not been delivered in the last shipment. When asked if hand sanitizer dispensers had been placed in additional, convenient areas for staff access, Central Supply Staff X revealed they were unaware of additional hand sanitizer dispensers being placed in the facility. On 9/12/25 at 9:17 AM, CNA T was observed entering Resident #2's room without donning PPE. CNA T picked the oxygen tubing up from that Resident #2 had been wearing without wearing gloves and/or any PPE and proceeded to exit the room. CNA T did not wash their hands, nor did they perform hand hygiene prior to entering another Resident's room to provide care. Infection Control Program An interview and review of facility IC data was completed on 9/12/25 at 12:24 PM with IC RN C. When asked how many residents were in TBP, IC RN C replied, Only have one person on actual TBP, (Resident #2). When queried regarding observation of CNA T entering Resident #2's room without PPE, picking up their oxygen tubing off the floor, exiting Resident #2's room, and then entering another Resident's room without performing hand hygiene, IC RN C responded that CNA T should have worn PPE when entering the Resident's room. When queried regarding observation of CNA T not wearing PPE while proving direct care to Resident #1, when they were visibly soiled, IC RN C confirmed Resident #1 has EBP in place and PPE should be worn when direct care is provided. IC RN C was then asked what the most important thing that staff can do to prevent the spread of infection and stated, Hand hygiene. When queried regarding all the hand sanitizer dispensers in the facility being empty, IC RN C verbalized they were aware and that it was due to the sanitizer being recalled. When queried if individual hand sanitizers were provided to staff, IC RN C responded they did not know. IC RN C was informed that hand sanitizers were not provided to all staff and replied, But it is available on the (medication) cart and in PPE carts. When queried if those locations readily accessible to all staff, IC RN C indicated staff are also able to wash their hands in Resident bathrooms. When asked if some of Resident rooms have shared bathrooms, IC RN C confirmed they do. When queried how staff are able to wash their hands if another resident is in the bathroom, IC RN C did not provide an explanation. When queried how staff were ensuring their hands remained clean when performing hand hygiene in a resident's personal sink and then exiting through the resident room, no explanation was provided. IC RN C was asked again if hand hygiene supplies were readily available and was unable to provide further explanation. When queried if the facility had an infectious organism outbreak since their last annual survey, IC RN C replied, Yes, October of last year. When asked what the outbreak was, IC RN C stated, Covid. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The October 2024 IC Monthly Analysis and Summary, employee call in documentation and line listing documentation for October 2024 was reviewed with IC RN C at this time. The Monthly Analysis and Summary specified there were 19 Healthcare-associated Infections (HAIs) and four Community Acquired Infections (CAI) during the month of October 2024 for a total of 23 infections. Per the analysis/summary, Communicable Disease Identified: 10 resident and 3 staff members tested positive for Covid. 1 resident has shingles. The analysis included the narrative summary for Explanation of Outliers/Trends. For the month of October there was a total of 23 overall infections. 19 were in house infections while there were 4 admitted to facility with. In house infections included 10 Covid positive, 2 pneumonia, 3 elevated WBCs (While Blood Cells – increase when there is an infection), 3 UTI (Urinary Tract Infections) and 1 Shingles. The admitted with infections included 1 pneumonia, 1 osteomyelitis (bone infection), 1 thrush (oral yeast infection) and 1 right knee infection. There were a total of 15 employee illness related call-ins. All were for 'Sick'. There was correlation between employee and resident infections noted at this time with a staff member testing positive for Covid after being exposed on the dementia unit. A review of the provided employee call in tracking list revealed 14 employee call ins with Staff Z listed twice 10/21/24. The reason listed for each of the employee call ins was sick or sick/sinuses. None of the employees were identified as having tested positive for Covid-19. When asked who the staff member was that tested positive for Covid, IC RN C stated, Does not say. I don't know if the report pulled over right. IC RN C revealed they were unable to recall the positive employees. When asked if a trend was identified and where they determined the infection originated from, IC RN C replied that the Covid outbreak was isolated to the locked dementia unit but was unable to provide further explanation. Review of the October 2024 line listing revealed 34 resident infections which included seven carry-over infections from September 2024 and 27 infections new infections for the month. IC RN C was asked to count the number of infections on the line listing, not including carry-over infections from September. IC RN C counted and confirmed there were 27 infections listed. Further review of the line list revealed the 27 infections involved 23 Residents. When asked if they were counting the number of infections or the number of residents who had an infection, IC RN C replied that they count the number of infections. The IC Mapping Tool for October 2024 was reviewed with IC RN C. Twenty seven infections were identified on the map. When queried regarding the discrepancy in the number of infections identified on the line list/map and Monthly Analysis/Summary, IC RN C stated, That was just me not knowing how to count. When queried regarding the accuracy of infection data reported for October 2024, IC RN C verbalized the analysis data for the month was inaccurate as the total number of infections for the month was inaccurate on the analysis. IC RN C revealed they were new in the IC role in October 2024. A more detailed analysis of the IC line listing for October 2024 revealed the line listing included the headings, Name, Type (resident or staff), admit date , Admit from, Acquired, Onset Date, Infection Category, Organism, Medication, Resolved, General Comments, Room/Bed. None of the residents included on the line list were identified as having Covid-19. Of the 27 infections for October 2024, Other was listed as the Infection Category for 17 of the resident infections and Covid was not listed as the Organism for any of the infections. When asked why Covid was not specified as the infectious organism for any of the infections, IC RN C revealed they use a program to complete their IC tracking and were unable to explain why the information was not on the list. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #92 was included on the line list for both a current and carry over infection. The line listing for the current infection specified Resident #92's admit date was 11/1/24 and the onset date of the infection was 10/24/24 with a resolved date was 12/12/24. The infection was listed as Prior and the category was other. The line listing detailed Resident #92 was treated with Daptomycin, Daptomycin (antibiotic used to treat complicated bacterial infections). The General Comments sections specified, MRSA (Methicillin-resistant Staphylococcus aureus- antibiotic resistance bacteria) is right dialysis port. Resident is to receive IV (Intravenous) Vanco (antibiotic) and daptomycin at dialysis. The carry over infection listed for Resident #92 specified the Resident was admitted to the facility on [DATE] and had a HAI UTI with an onset date of 9/12/24 and a resolved date of 10/12/25. Organisms were not listed for either infection. When queried when Resident #92 was admitted to the facility, IC RN C revealed they were unsure. A review of Resident #92's Electronic Medical Record (EMR) revealed the Resident was originally admitted to the facility on [DATE]. RN C was asked why the infection for October 2024 was listed as Prior and why the admission date was different for the infections. IC RN C reviewed Resident #92's EMR and stated, On 10/23/24, (Resident #92) was sent to ER. IC RN C revealed they were unsure why the admission dates were not the same as that information is generated by the computer system. When queried regarding the Resident's onset date of infection beginning on 10/24/25 if they were sent to the ER on [DATE], IC RN C stated the onset date was an error. When asked what the Resident's signs/symptoms of infection were, IC RN C reviewed the EMR and stated, Fever and change in mental status on 10/23. When queried if the infection was diagnosed at the hospital, IC RN C revealed it was. When asked why it was listed as Prior and not HAI, IC RN C indicated that was how it was set up in the computer tracking system. IC RN C was then asked if Cultures were completed and what the causative organism of the infection was and revealed they were unable to answer as the information was not included on the line list. The IC documentation for June 2025 was reviewed with IC RN C next. Review of the line listing for June 2025 revealed a total of 17 infections including eight new and nine carry over infections. Of the eight infections which occurred in June 2025 two were identified as HAI, three were identified as CAI, and three were listed as NA under the Acquired column. The June 2025 Mapping Tool identified 10 infections. The June 2025 Monthly Analysis and Summary detailed the total number of resident infections for the month was 10 with three HIA infections. When queried regarding the discrepancies in the number and classification of the infections, IC RN C confirmed the numbers did not match. When asked why some of the infections were listed as NA under the acquired column, IC RN C revealed some of the antibiotics were prophylactic and were not used to treat an actual infection. The line list did not include the resident signs and symptoms of infection on the line list. When did not include when treatment was initiated if the onset date was the date the signs and symptoms began. When asked, IC RN C verbalized understanding but further explanation was not provided. When queried why the specific infection type and location was not listed for each infection, IC RN C relayed they would need to look up each resident's medical record to provide the information as it is not included on the IC line list. Review of facility provided policy/procedure entitled, Hand Hygiene (Reviewed/Revised: 12/13/23) revealed, Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	within the facility. 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Hand Hygiene Table. When coming on duty. Between resident contacts. After handling contaminated objects. Before applying and after removing personal protective equipment (PPE), including gloves. Before and after handling clean or soiled dressings, linens, etc. Before performing resident care procedures. Before and after providing care to residents in isolation. After handling items potentially contaminated with blood, body fluids, secretions, or excretions. When, during resident care, moving from a contaminated body site to a clean body site. After assistance with personal body functions. Review of facility provided policy/procedure entitled, Infection Prevention and Control Program (Reviewed/Revised: 10/24/22) revealed, Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections. 3. Surveillance: a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals. 4. Standard Precautions: a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. 5. Isolation Protocol (Transmission-Based Precautions): a. A resident with an infection or communicable disease shall be placed on transmission-based precautions. Upon request for a policy/procedure related to transmission-based precautions, the facility provided a policy/procedure entitled, Personal Protective Equipment (Reviewed/Revised: 12/7/23). The policy specified, This facility promotes appropriate use of personal protective equipment to prevent the transmission of pathogens to residents, visitors, and other staff. Policy Explanation and Compliance Guidelines: 1. All staff who have contact with residents and/or their environments must wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely. 2. PPE will be utilized as part of standard precautions regardless of a resident's suspected or confirmed infection status. 3. Multiple factors determine the appropriate selection of PPE for a particular task: a. The type of exposure anticipated (e.g., splash/spray versus touch) b. The volume of fluid or tissue to which there is a potential exposure c. The likelihood of exposure d. The probable route of exposure (e.g., direct contact versus inhalation) e. The need for transmission-based precautions. Observation was made during medication pass on 9/10/25 at 11:30 a.m., of med tech L pass medications. Med Tech L gave eye drops wearing clean gloves; she entered the room, immediately put clean gloves on (the ones she had gotten from the med cart), when she was done giving the eye drops, she removed her gloves, walked directly into the hallway, tried to get hand sanitizer from the hallway container and stated, O ya, there is no hand sanitizer, it was recalled. She continued down the hallway, got to the medication cart, immediately entered the eye drops as given on the computer, and then used the hand sanitizer sitting on top of the cart. Med Tech L did not wash her hands prior to putting gloves on (in the residents room bathroom) and immediately after removing her contaminated gloves. Med Tech L said all the hallway hand sanitizer had been removed about 2 days' ago because it was recalled. No individual (smaller hand sanitizer container) was available for staff to use other than the larger container sitting on top of the medication cart in the end of C's hallway, in the alcove, leading to cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview done on 9/10/25 at approximately 3:00 p.m., the Director of Nursing/DON stated yes, she should have washed her hands in the residents bathroom, we taught her that. Review of the facility Hand Hygiene policy dated 5/7/2020, stated The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Review of the facility Medication Administration policy dated 1/17/2023, stated Wash hands using facility protocol and product. Review of the facility Personal Protective Equipment policy dated 12/7/2023, stated Change gloves and perform hand hygiene between clean and dirty tasks.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to implement and operationalize a comprehensive Antibiotic Stewardship Program including documentation and treatment for three residents (#31, #35, and #44) of three residents reviewed for antimicrobial treatment and the potential to affect all facility residents by means of unnecessary and inappropriate antibiotic and antimicrobial medication utilization, antibiotic resistance, and ongoing infection.Findings include:An interview and review of facility Infection Control (IC) and antibiotic utilization data was completed on 9/12/25 at 12:24 PM with IC Registered Nurse (RN) C. When queried what criteria the facility utilizes for antibiotic use and infections, IC RN C replied, McGeer (standardized criteria providing guidelines for antibiotic use). A review of the facility IC documentation for October 2024 was completed. The Monthly line listing documentation provided did not specify if the infection being treated with an antimicrobial medication met McGeer criteria. The IC Monthly Analysis and Summary for October 2024 included a section entitled, Antibiotic Stewardship. The section detailed, Antibiotic Use Reported to Prescribing Providers. Printed off and given to provider. The monthly analysis did not specify if any infections did not meet McGeer criteria. When queried how they were monitoring antibiotic use to ensure residents do not receive unnecessary treatment and receive treatment with the appropriate antimicrobial medication, IC RN C revealed the computer system identifies if an infection meets McGeer criteria when they enter the information. When queried if any of the listed infections did not meet criteria for treatment, IC RN C revealed they were not sure. IC RN C was asked what the Antibiotic Use Report provided to the Health Care Provider was and provided a list of antibiotics prescribed during the month. The provided list did not specify if the antimicrobial agent meet criteria for treatment. Review of the October 2024 line list revealed Resident #92 was listed twice for both a current and carryover infection. The information on the line list for the carry over infection specified, the Resident had a Healthcare-associated Urinary Tract Infection (UTI) with an onset date of 9/28/24 and resolved date of 10/12/24. The Resident received cephalexin (antibiotic) but the causative organism was not identified on the line list. When queried if Resident #92's infection met McGeer criteria. IC RN C indicated they did not know. When asked if the Resident had a urinalysis (UA) with Culture and Sensitivity (C&S), IC RN C stated, There was no (microorganism) growth. When queried if the antibiotic was stopped when the UA showed no growth, IC RN C reviewed the Resident's Electronic Medical Record (EMR) and revealed the antibiotic was continued. When queried regarding documentation that the antibiotic use was addressed with the Health Care Provider, IC RN C was unable to provide documentation. Resident #92 was included on the line list for a new infection in October. The line list specified Resident #92 was treated with Daptomycin, Daptomycin (antibiotic used to treat complicated bacterial infections). The General Comments sections specified, MRSA (Methicillin-resistant Staphylococcus aureus- antibiotic resistance bacteria) is right dialysis port. Resident is to receive IV (Intravenous) Vanco (antibiotic) and daptomycin at dialysis. When queried regarding the wound C&S and causative organism, IC RN C revealed the Resident went to the hospital on [DATE] and returned with the antibiotic orders. IC RN C revealed the C&S is most likely in the hospital records, but they did not have the information readily available in their IC tracking. Review of facility provided policy/procedure entitled, Antibiotic Stewardship Program (Reviewed/Revised: 12/13/23) revealed, Policy: It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to prevent facility-acquired urinary infections for 4 residents' (#31, # 35, #44, #70) of 4 sampled residents, resulting in likelihood for recurrent urinary tract infections with prolonged illness or hospitalization and antibiotic therapy.Findings include: Resident #31:Observation, interview and record on 9/10/2025 at 10:10 AM estimated of Resident #31 during the initial screening process of the annual recertification survey the resident was verbal with confusion and could not recall having a urinary tract infection. Record review of Resident #31's 8/6/2025 Minimum Data Set (MDS) identified the resident with a Brief Interview of Mental status (BIMs) of 4 out of 15, severe cognitively impaired. Record review on 09/10/2025 at 2:34 PM of Resident #31's urology office visit note dated 7/9/2025 noted hematuria (blood in urine) and urinary tract infection. Ordered Macrobid 100mg capsule oral, one tablet twice daily for 30 capsules.Record review on 09/10/2025 at 2:39 PM of Resident #31's July Medication Administration Record (MAR) revealed that the resident received an antibiotic Macrobid 100mg twice daily for 15 days for UTI (Urinary Tract Infection). The antibiotic Macrobid was started on 7/10/2025 through 7/25/2025 twice daily orally. Record review of the facility July 2025 ?Antibiotic Dispensed' report dated 7/1/2025-7/31/2025, noted Resident #31 received Macrobid 100mg capsule by mouth two times a day for UTI until 7/25/2025. Record review of the facility July 2025 ?Antibiotic line Listing' form noted Resident #31 was admitted on [DATE] developed a urinary tract infection was treated with Macrobid 100mg oral for 15 days. Organism was noted as ?Null'.An interview and record review on 09/11/2025 at 2:38 PM with Registered Nurse/Infection Control Preventionist C in regard to Resident #31's urinary Tract Infection in July 2025 revealed RN C to review the record and stated the urinary Tract Infection onset/start was 7/10/25 with signs/symptoms from urologist office visit and the urine came back positive, the urologist placed resident (#31) on Macrobid 100mg BID x 15days. The state surveyor inquired about what organism was being treated. RN C stated that the urologist office did not identify an organism, and the facility did not do a Culture and Sensitivity (C&S). There was no risk vs benefit from physician found for medication of antibiotic with no culture within the medical record. RN C stated that there was not one done. Resident #35:In an interview and observation on 09/12/2025 at 9:42 AM with Resident #35 revealed that she does not want to go to the dining room and does not like the foods. During the interview Resident #35 was observed to get up from the bed and walked to the restroom and shut the door and in a few moments came back to lie on the bed. Resident #35 stated that she has been having bladder problems lately and was taking pills for it. Record review of Resident #35's progress notes dated 9/8/2025 at 9:30AM noted: 9/3/25 UA (urinalysis) positive UTI (Urinary Tract Infection). NP (Nurse Practitioner) at facility. New order for Macrobid 100mg BID (twice daily) time 5 days. No organism was identified in the progress notes. Progress notes dated 9/10/2025 and 9/11/2025 noted Resident #35 complained of loose stools. (Side effect of antibiotic medication) Record review of Resident #35's electronic medical record revealed that there was no culture and sensitivity (C&S) found within the medical record. In an interview and record review on 09/11/2025 at 2:38 PM with Registered Nurse/Infection Control Preventionist C in regard to Resident #35's recent Urinary tract infection revealed: Registered Nurse C stated that the urinary infection started 9/3/25 when the facility urine sample for analysis was sent out for a Kidney/blood pressure appointment and it came back positive, and we have not received a culture back from the office yet. RN C stated that Yes, antibiotic was started with no organism known. It was Macrobid 100mg BID (twice daily) for 5days. Resident #35 would finish the antibiotic on 9/13/2025. RN C was asked about a facility risk vs benefit from physician and that none was found for the antibiotic medication with no organism or culture. RN C stated that there were no risk vs benefit statements for the residents because she was unsure of what to do when there is antibiotic use with no organism identified. Resident #44:Record (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident #44's admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental status of 2 out of 15, severe cognitive impairment. Medical diagnosis included: atrial fibrillation, hypertension, renal insufficiency, arthritis, hemiplegia/hemiparesis, malnutrition, and stroke. In an interview and record review on 09/11/2025 at 2:38 PM with Registered Nurse/Infection Control Preventionist C in regard to Resident #44 revealed RN C stated that the urinary tract infection (UTI) started on 9/5/2025 when the resident #44 went to the emergency room (ER) for chest pain/shortness of breath (SOB) and came back with a UTI. The state surveyor inquired about what the Organism was that the facility was treating. RN C stated that We have to call the ER/hospital to get a culture, that needs to be done yet. RN C stated that there were no risk vs benefit statements for the residents because she was unsure of what to do when there is antibiotic use with no organism identified. Record review at the time of the interview revealed that there were no urine culture or sensitivity found within the medical record on 9/11/2025. RN C was notified that the state surveyor had identified three residents that received antibiotic therapy for urinary tract infections with no organisms identified. RN C stated i will have to track those cultures and organism down and I will as soon as I leave here. The state surveyor asked What happens if not treating the correct organism? RN C stated that we will create antibiotic resistant bugs (MDRO). MDRO- Multi-Drug Resistant Organism. Record review of Resident #44's September 2025 Medication Administration Record revealed that on 9/5/2025 Cephalexin (Keflex) 500mg capsule by mouth three times daily for UTI for 10 days antibiotic was started on 9/5/2025 through 9/12/2025. On 9/12/2025 the antibiotic Cephalexin was changed to Ciprofloxacin (Cipro) 250mg tablet by mouth two times a day for UTI. Resident #70: Observation on 09/10/2025 at 12:19 PM Resident appears sleepy and kept falling asleep during interview. Record review is receiving Macrobid 100mg capsules for UTI currently. Observation on 09/10/2025 at 3:26 PM Resident #70 seated up in wheelchair at nursing station with large thermal mug gray in color, Resident has on sunglasses and headphones over his ears. Resident #70 has an odor of yeast noted by surveyor. Record review of Resident #70's Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview of Mental status of 9 out of 15, moderate cognitive impairment. Section GG Functional Abilities: toileting hygiene as partial/moderate assist from staff. Record review of Resident #70's September 2025 Medication Administration Record revealed Macrobid 100mg capsule one by mouth two times a day for UTI for 7 days. Macrobid 100mg started on 9/4/2025 through 9/11/2025. Record review of Resident #70's progress note dated 9/4/2025 at 8:00AM noted Urinalysis with culture positive for Escherichia Coli (E.coli) , Macrobid 100mg BID (twice daily) for 7 days ordered. In an interview and record review on 09/11/2025 at 2:43 PM with Registered Nurse/Infection Control Preventionist C regarding Resident #70's development of facility acquired urinary tract infection revealed that a urinalysis collected on 9/3/25 and was positive for E.coli by culture and sensitivity (C&S), Macrobid (antibiotic) 100mg BID x7 days. S/S of had burning with urination, discomfort and odor. Record review of Resident #70's urinary incontinence task record from 8/14/2025 through 9/11/2025 (30 day look back) revealed 50 out of 57 documented incontinence episodes of urine. Task B&B: Bladder Elimination Description (question 2) revealed that the resident was on a check and change program. Record review of the 'Facility Assessment tool' dated 7/2024 through 6/2025, presented by the facility revealed on page 15-16, Services and care based on Resident Needs: Infection Prevention and control- Identification and containment of infections, prevention of infections. Record review of the facility 'Antibiotic Stewardship Program' policy dated 12/13/2023, revealed it was the policy of the facility to implement an antibiotic stewardship program, as part of the facility overall infection prevention and control program. The purpose of the program was to optimize the treatment od infections while reducing the adverse events associated with antibiotic use. The infection Preventionist, with oversight from the Director of Nursing, serves as the leader of the antibiotic stewardship program and receives support from the Nursing Home Administrator and other governing officials of the facility. The Medical Director, Consultant pharmacist, and attending physicians support the program via active participation in developing, (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	promoting, and implementing a facility-wide system for monitoring the use of antibiotics. Antibiotic Use Protocols: Laboratory testing shall be in accordance with current standards of practice Whenever possible, narrow-spectrum antibiotics that are appropriate for the condition being treated shall be utilized.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure safe medication storage for 2 residents (Resident #30 and Resident #33) of 18 residents reviewed for medications left in rooms, resulting in the potential for ingestion of medications. Findings include: Resident #30: On 9/10/25 at 10:53 AM, Resident #30 was observed sitting in a chair on the left side of their bed and an interview was completed. During the interview, a clear cup containing medication pills was observed sitting on a bedside dresser table next to a clear plastic cup of water on the right side of the Resident's bed. The medication cup contained several different size and colored pills. The number of pills in the cup was unable to be accurately counted due to the way the pills were in the cup. When queried regarding the medications, Resident #30 revealed the nurse had left them there for them to take. When asked if the nursing staff always leave their medications in their room, Resident #30 replied some nurses do and some nurses stay in the room and watch them take the medications. At this time, Resident #30's room was exited, and their nurse was attempted to be located. The Resident's assigned nurse was not in the hallway nor were any nurses present at the nurses' station. The Director of Nursing (DON) was not in their office. MDS Registered Nurse (RN) N was observed sitting in their office and asked to come to Resident #30's room. At 10:58 AM on 9/10/25, MDS Registered Nurse (RN) N was observed sitting in their office and asked to come to Resident #30's room. Upon entering Resident #30's room, MDS RN N confirmed the presence of the container of multiple pills in the room. Upon request, MDS RN N counted the medications and verbalized there were Eight pills in the cup. When asked if Resident #30 had been assessed for medication self-administration, MDS RN N revealed they did not believe they were but would check. When queried what the medications were, MDS RN N responded they would have to check as they did not have keys to the medication cart and there were no nurses present in the hallway and/or at the nurses' station. On 9/10/25 at 11:02 AM, MDS RN N returned to Resident #30's room and stated Resident #30 did not have a self-med admin assessment. When asked if that meant the Resident had not been assessed and deemed capable of administering their medications without nursing supervision, MDS RN N confirmed. MDS RN N verbalized they were still working on identifying the medications. On 9/10/25 at 1:00 PM, MDS RN N revealed they identified the medications found unattended at Resident #30's bedside and provided the following list of medications: - One Carbidopa-Levodopa 25/100 milligram (mg) tablet (medication commonly used to treat Parkinson's disease) - One Digoxin 125 microgram (mcg) tablet (commonly used to treat Congestive Heart Failure [CHF]) - One Doxycycline 100 mg tablet (antibiotic medication) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One Fluoxetine 20 mg capsule (commonly known as Prozac and used to treat depression) - One Actos 45 mg tablet (medication used to treat diabetes) - One Acidophilus capsule (over the counter probiotic medication used to support digestive health) - One Glipizide 10 mg tablet (medication used to treat diabetes) - Diltiazem Extended Release 120 mg capsule (medication used to treat high blood pressure and some cardia arrhythmias) Review of Resident #30's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses which included left femur fracture, diabetes mellitus, surgical infection, and Parkinson's disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required supervision to total assistance to complete Activities of Daily Living (ADLs) with the exception of eating. Review of Resident #30's Medication Administration Record (MAR) revealed the medications listed were documented as being administered together daily at 8:00 AM every morning and had been documented as administered on 9/10/25 at 8:00 AM. Further review of Resident #30's Electronic Medical Record (EMR) revealed the Resident had not been assessed for self-medication administration. An interview was completed with the DON on 9/12/25 at 11:52 AM. When queried regarding the unattended medications observed in Resident #30's room, the DON indicated they were aware and verbalized the medications should not have been left at the Resident's bedside. No further explanation was provided. Review of facility policy/procedure entitled, Medication - Resident Self-Administration of (Reviewed/Revised: 1/30/24) revealed, It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. 7. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication. The following conditions are met for bedside storage to occur: a. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if locked storage is ineffective. b. The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy. Review of facility policy/procedure entitled, Medication Administration (Reviewed/Revised: 1/17/23) revealed, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 15. Observe resident consumption of medication. Review of facility policy/procedure entitled, Medication Storage (Reviewed/Revised: 1/30/24) revealed, . Policy Explanation and Compliance Guidelines: 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments (see attached listing). c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Resident #33: Review of the Face Sheet, care plans 5/22/23, Brief Interview for Mental Status (BIMS) dated 7/30/25, and physician orders dated 8/26/25, revealed Resident #33 was [AGE] years old, admitted to the facility on [DATE], totally dependent on staff for all Activities of Daily Living/ADL, received Hospice services, and was on the locked Dementia unit. The resident's diagnosis included, age-related nuclear cataract bilateral, Dementia, mood and behavioral disturbances and anxiety. Review of the BIMS dated 7/30/25, revealed that the resident's cognitive assessment score was 3, severely cognitively impaired with memory loss. Review of the physician order dated 8/26/25, stated Apply house fungal powder every shift to red area under left breast and belly button until resolved. Review of the residents impaired cognitive function/impaired thought care plan dated 5/22/23, revealed she required simple, one word, slowly spoken directions due to decreased cognition; she was safety awareness impaired. Observation was made during the initial Dementia unit's tour done on 9/10/25 starting at 10:00 a.m. In the resident's room was found an open bottle with no top within sight of Nystin Powder (anti-fungal powder) sitting on the left side of the bed on the windowsill. At the time, there were several residents on the unit walking around by themselves. The resident was walking in the hallway by herself at the time. This surveyor went and got the nurse on the unit (Nurse, RN M). During an interview done on 9/10/25 at 10:45 a.m., Nurse M stated There were two nurses on last night, they are the only one's who put it (Nystin powder) on. Nurse M said the top should have been on the bottle and it should not have been left in a resident's room.

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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 observation, interview and record review, the facility failed to update/revise individualized, person-centered care plans to reflect changing care needs for 1 resident (Resident #9), of 18 residents reviewed for care plans. Findings include: Resident #9: Record review of the facility provided CMS-802 'Resident Matrix' identified Resident #9 as had a fall with injury. In an observation and interview on 09/10/2025 at 10:19 AM with Resident #9 revealed that she was laying on the top of her bed with the room partition/privacy curtain pulled so that the resident could not be observed from the doorway of the room. Resident #9 stated that she did have a fall at her closet but could not recall when the fall had occurred. Resident #9 stated that she did have a broken arm from the fall and tailbone pain. identified a fall with major injury and resident stated that she had a fall at her closet. Observation on 09/11/2025 at 10:34 AM of Resident #9 was noted to be lying in bed with the room partition curtain pulled between beds and the resident was not able to be seen from the hallway. Resident #9's legs and feet are off the bed, and she has taken her shoes off with no grippy socks noted. Shoes at bedside. Observation on 09/12/2025 at 10:36 AM resident observed up in activity sitting outside in the sun on back patio area with 6 other residents and a volunteer. Resident appears a sleep and leaning to the left of WC. In an interview and record review on 09/12/2025 at 11:30 AM with the Director of Nursing regarding Resident #9's repeat falls:Fall on 3/4/2025 fall with Fractured wrist and pelvis. Record review of Resident #9's 'Un-witnessed Fall' form dated 3/4/2025 at 5:45PM the Resident #9 was found on the floor by CNA in resident room. Resident #9 was then Hoyer lifted off the floor. pain was noted, 2 days later she sent to the ER hospital x-rays of fractured wrist and pelvis. The state surveyor asked if the incident was reported to the state as it was an unwitnessed fall. DON did not know and referred the surveyor to the Nursing Home administrator.Observed on Floor fall on 4/22/2025 at 7:50PM Resident #9 was found on the floor in her room between her bed and wheelchair. Observed on Floor fall on 7/4/2025 at 00:20AM resident was observed to be lying on the floor on her stomach with a left side of her head resting on the floor with a laceration. Resident was not wearing any footwear. Resident complained of being very dizzy and did not feel good Sent to emergency room to be evaluated. Resident #9 received 2 sutures to the scalp laceration Record review of Resident #9's Care Plans pages 1-36 for updated fall interventions with the Director of Nursing revealed that there were no new interventions added to the fall/injury care plan after the 7/4/2025 fall with laceration to the head. Record review of the facility 'Comprehensive Care Plan' policy dated 6/30/2022 revealed that it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents' rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to identify skin breakdown for three residents (#3, #13, #70) resulting in the lack of implementation of interventions to prevent skin injury, the worsening of skin injuries, pain, discomfort, and the likelihood of prolonged illness or hospitalization.Findings include: Resident #3:An observation and interview on 09/11/2025 at 8:38 AM of Resident 3 revealed that there were sore spots to the resident's buttocks area and the nurses apply a cream to the area and take photos sometimes. During the survey the surveyor observed Resident #3 to be non-ambulatory related to Parkinson's disease and was able to self-propel wheelchair to the dining room. Resident #3 stated that he does use a WC for ambulation and does spend a lot of time in bed. Observed an air mattress in place to the bed. Resident #3 stated that he was the president of the resident council for residents' concerns and that he had no issues or concerns with the facility. Record review of Resident #3's 8/28/2025 Moisture associated Skin Damage (MASD) assessment with photo revealed a new wound, incontinence associated dermatitis. The photo revealed open skin areas to bilateral buttocks regions with scabs noted. Record review of Resident #3's skin progress note dated 8/28/2025 at 10:25 AM noted new skin issue: Location: Coccyx measurements of 1cm width X 1cm length with other red-purple areas with peeling of outer sites. Observation and interview on 09/12/2025 at 9:16 AM with Certified Nurse Assistant (CNA) K of Resident #3's coccyx region, soaked/wet brief lowered, and resident was rolled to his left side. Observation of the bilateral buttocks noted that there is no cream noted to area, bleeding was noted on brief from the skin that was beefy red with bleeding noted to the surface. The buttocks area had open and fragile areas along the cleft of the left buttock's region. An air mattress noted to bed, brief was wet with strong odor of urine. The CNA K was left with the resident to perform peri care and change the brief. Observation and interview on 09/12/2025 at 10:52 AM with Licensed Practical Nurse (LPN)/Wound Care Nurse F of Resident #3's left buttocks area. Upon entering the room Resident #3 was rolled to the right side. The state surveyor and the LPN F observed the wet/soaked brief still in place on the resident with strong odor of urine noted. Resident #3 stated that he was last changed about 1AM. Observation of Resident #3's bilateral buttocks region noted 2 sites of pressure on right upper buttocks and the left cleft of left buttocks region. LPN F with gloves on touched the areas for blanching of the skin. The state surveyor inquired about what was the difference between Moisture Associated Skin Damage (MASD) and the beginning stages of pressure ulcers. LPN F stated that she will have to make a change to classification and stage as pressure although not open yet, and that she had 3 areas of concern that are new areas as of that day for Resident #3's buttock region.Record review of Resident #3's 9/12/2025 ?Pressure ulcer/injury' assessment revealed a coccyx pressure ulcer/injury, in the progress of deteriorating. Pressure ulcer staging: Stage 1 pressure ulcer with non-blanchable erythema with skin intact. Record review of Resident #3's skin issues progress note dated 9/12/2025 at 12:27PM noted: Stage 1 pressure ulcer/injury to the coccyx, non-blanchable erythema of intact skin. Wound acquired in-house. Wound is greater than 3 months old. Intermittent pain of aching was documented. Licensed Practical Nurse (LPN) F documented site has deteriorated in past 2 days. Two new areas of dark red purple are present. One to the left buttock and one to the right intergluteal fold. Continue barrier cream, air mattress to bed, encourage repositioning and hygiene during episodes of incontinence. Resident #13: In an interview on 09/10/2025 at 11:01 AM with Resident #13 stated that she has thin skin on her bottom and that there are several little sores in the butt crack, and in her groin area also that are open spots. The area gets damp, and the skin is fragile is what they tell her. Resident #13 did state that the areas do hurt and are uncomfortable.Record review of Resident #13's ?Skin Assessment and photos' noted Moisture associated Skin Damage (MASD) on 9/2/2025 with measurements of 1.32cm length X 1.08cm width.Observation on 09/11/2025 at 1:07 PM with Certified Nurse Assistant (CNA) V and W entered the room, gloved and lowered the head of the bed. Resident #13 was then rolled to her left side and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her brief was lowered, to observe the rear left thigh with open areas, with bleeding noted in the brief. Resident #13 complained of discomfort with touching of the areas by CNA. The CNA V cleansed the area wet wash cloth and applied Chamosyn with manuka honey cream to the area, and a new brief was applied. During the observation the CNAs and surveyor observed 5 open small areas noted with bleeding. In an interview on 09/12/2025 at 10:40 AM with Licensed Practical Nurse (LPN) F wound care nurse regarding resident #13's MASD- Moisture associated skin damage. LPN F was asked if MASD damage bleeds. LPN F stated that yes, some do. That would mean it's open wound if bleeding. Stage II pressure ulcer- is an open skin with bleeding with discharge with more than the just the top surface missing. The state surveyor described the observation that took place on 9/11/2025 with CAN staff of Resident #13's buttocks observed with 5 open area with bleeding into brief. LPN F stated that the Treatment Chamosyn manuka Honey. The state surveyor inquired about the moisture associated with skin damage and pressure ulcer staging. LPN F stated that We discuss wounds weekly, on Tuesdays with photos and discuss if need to be reclassified. So far, we have not changed Resident #13's classification. Resident #70: Observation on 09/10/2025 at 3:26 PM Resident #70 is seated up in wheelchair at nursing station with large thermal mug gray in color, Resident has sunglasses on and headphones over his ears. Resident #70 has an odor of yeast noted by surveyor.Record review of Resident #70's urinary incontinence task record from 8/14/2025 through 9/11/2025 (30 day look back) revealed 50 out of 57 documented incontinence episodes of urine. Task B&B: Bladder Elimination Description (question 2) revealed that the resident was on a check and change program. The staff must change the residents brief and cleanse their skin with each incontinence episode. In an interview and observation on 09/12/2025 at 9:47 AM with Resident #70 was observed to be lying in bed on top of the covers. Resident #70 called to the state surveyor through his doorway to let the state surveyor know that his groin was sore and that it hurt between his penis and balls. Resident #70 stated it hurts a lot. No there is no cream for it. The whole area is on fire. Observation on 09/12/2025 at 9:50 AM with Certified Nurse Assistant (CNA) Y assisted with observation of Resident #70's peri area. Resident #70 was positioned on the bed and his pants and brief were removed. Observation of Resident #70's groin/peri area was noted to be red on both sides of the groin and behind the scrotum area with skin peeling at the edges. A strong yeast odor was noted. Resident #70 stated that it has been sore since he moved to this room, not all the time but once in a while. Brief wet and soaked. Observation on 09/12/2025 at 9:56 AM of Resident #70's groin redness with the Director of Nursing (DON) and Certified Nurse Assistant (CNA) Y observed with surveyor, area was noted red and the DON told CNA Y to wash with soap and water and pat dry and apply AD ointment. The DON stated that she was not aware of the skin issue. In an interview on 09/12/2025 at 11:03 AM with Licensed Practical Nurse (LPN) F wound/skin care nurse regarding Resident #70's complaint of groin pin/discomfort revealed that LPN F was not aware of the redness to the groin and has not been seen by wound nurse yet. In an interview on 09/12/2025 at 1:46 PM with Licensed Practical Nurse (LPN) F regarding Resident #70 skin issue revealed: I looked at his groin and testicles and it smells of yeast, so I called and updated the doctor and ordered Nystatin BID for 2 weeks. It is a smelly yeast with flaky edges and its spreading. I updated the orders and notes. Record review of Resident #70's nursing progress note dated 9/12/2025 at 1;30PM documented: Assessed groin, redness presents with edges of reddened areas round in shape. Noted odor, white yeast like on skin. Notified physician, new orders for Nystatin powder to groin and scrotum BID (twice daily) for 10 days.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that Peripherally Inserted Central Catheter (PICC) line care was provided, per professional standards of practice, for one resident (Resident #2) of one resident reviewed, resulting in a lack of sterile technique during dressing change and a lack of accurate measurement of arm circumference. Findings include:Resident #2:On 9/10/25 at 10:14 AM, A Contact Precaution sign was observed on Resident #2's room door. Activity Aide S was observed in the hallway near the Resident's room. When asked if they knew the why Resident #2 had Contact Precautions in place, Activity Aide S stated, No. Certified Nursing Assistant (CNA) T was observed walking down the hall and was asked if they knew why Resident #2 had contact precautions in place and replied, (Resident #2) has a central line (PICC). When asked if the Resident had an infection, CNA T replied, No. Record review revealed Resident #2 was most recently admitted to the facility on [DATE] with diagnoses which included infection, rheumatoid arthritis (RA), Post Traumatic Stress Disorder (PTSD), and Chronic Obstructive Pulmonary Disease (COPD). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required set-up to substantial assistance to complete all Activities of Daily Living (ADLs). The MDS further indicated that the Resident was receiving IV medications and had a midline (longer peripheral IV catheter inserted into the upper arm with the tip of the catheter located at or near the armpit) for IV access. Review of Resident #2's Electronic Medical Record (EMR) revealed a care plan entitled, Resident has an IV Peripherally Inserted Central Catheter (PICC) line LUE (Left Upper Extremity) inserted 8/8/25 45 cm (centimeters) length. ABT (antibiotic) for MRSA (Methicillin-Resistant Staphylococcus Aureus - antibiotic resistant bacteria) Right Shoulder/arm (septic- extreme reaction of the body to an infection which causes widespread inflammation and can lead to organ failure and death) (Initiated: 8/15/25). The care plan included the interventions:- Ensure that IV attachments are tight fitting with Luer lock (Initiated: 8/15/25)- Gently palpate areas around and over site for tenderness, phlebitis, inflammation, infiltration, occlusion, or leakage from insertion site (Initiated: 8/15/25)- IV catheter care, maintenance, and dressing changes per orders (Initiated: 8/15/25)- IV medications / flushes per orders (Initiated: 8/15/25) Review of progress note documentation in Resident #30's EMR consistently referred to the Resident's IV access as a PICC line with no documentation indicating the Resident had a midline catheter. The Nursing Evaluation Summary note dated, 8/15/25 at 6:47 PM specified, Arrived from (hospital). Right shoulder drain sites with drainage. IV ABT via PICC to LUE. No s/s infiltration. Drsg (dressing) changed 8/14. Single lumen PICC inserted 8/8/25. 45cm length. PICC insertion Paperwork in chart. An observation of Resident #2 in their room was completed on 9/11/25 at 8:20 AM. The Resident had a PICC line in their left upper arm. The insertion site of the PICC line was reddened and the dressing was dated 9/4/25. The PICC line was connected to a bag of IV antibiotics via an IV infusion pump. The IV infusion was complete, and the pump was turned off. Licensed Practical Nurse (LPN) U entered the Resident's room at this time and an observation of them disconnecting and flushing the Resident's PICC line was completed. When asked if the Resident's LUE IV access was a midline or a PICC line, LPN U responded that it was a PICC line. LPN U did not check for blood return while flushing and did not flush the PICC line using a pulsating or push/pause method. The clamp lock on the PICC line had Check Blood Return and Flush inscribed on it. After exiting Resident #2's room, an interview was completed with LPN U. When asked why they did not assess for blood return when flushing Resident #2's PICC line, LPN U stated, I am under the assumption that you only check for blood return before administer antibiotics. When asked about the instructions on the PICC line clamp to check blood return and flush, LPN U reiterated they were only aware of the need to check for blood return prior to administration of medications. When queried if best practice is to flush the PICC line using a pulsating or push/pause method, LPN U replied, Not taught to, just do a slow flush. When queried regarding the (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PICC line dressing change, LPN U responded that they were unable to complete a PICC line dressing change and Registered Nurse (RN) M would do it later in the day. Review of Resident #2's Medication Administration Record (MAR) revealed documentation that the PICC line dressing was changed on 9/3/25. There was no documentation on the MAR that the dressing was changed on 9/4/25. Review of Resident #2's Health Care Provider (HCP) orders revealed the order, Transparent dressing change every 7 days and as needed. Supplementary documentation includes Arm circumference in cm (centimeters). Catheter Length in cm. An observation of Resident #2's LUE PICC line dressing change was completed on 9/11/25 from 2:00 PM to 3:15 PM with RN M. During the dressing change procedure, RN M had to call for assistance several times from staff outside of the room due to need for additional supplies. RN M removed the current Tegaderm (clear, transparent) dressing using clean technique. RN M then proceeded to remove the StatLock (adhesive-backed device that adheres to the skin with a mechanism to hold the PICC line in place) securement device while wearing clean gloves. While removing the Statlock device, RN M touched the PICC insertion site with their clean gloves. RN M then opened the sterile PICC line dressing change kit and began removing items from the kit. RN M threw the sterile drape in the garbage and then moved items in the kit to obtain the new Statlock device, the chloraprep skin cleaner, and the sterile gloves. RN M touched multiple items in the kit while not wearing sterile gloves. The sterile gloves in the PICC line dressing change kit broke while RN M was putting them on, and they did not have an additional pair of sterile gloves. RN M had to call for assistance from another staff member while leaving the PICC line insertion site uncovered. A staff member brought a pair of gloves, which they stated were sterile but were not individually wrapped sterile gloves and appeared to have been removed from another sterile kit. When asked about the gloves, RN M verbalized they would have preferred to have individually wrapped sterile gloves to ensure they were sterile but due to being unable to leave the Resident, they were dependent on other staff to assist. After donning the gloves provided, RN M was unable to secure the PICC line to the Statlock securement device due to a device malfunction. RN M called for assistance to have another staff member obtain additional supplies while the PICC line site was uncovered. RN M then attempted to measure the circumference of Resident #2's left arm with no dressing in place over the PICC line insertion site. RN M placed the measuring tape directly over the uncovered PICC line insertion site. RN M was stopped and asked if that was the appropriate place to measure arm circumference for PICC line placement and replied, No. During the dressing change, the exposed PICC line insertion site was observed touching the Resident's upper body due to their inability to easily move and maintain their shoulder and arm outward and away from their body. Upon exiting Resident #2's room, an interview was completed with RN M on 9/11/25 at 3:15 PM. When queried regarding observations of breaks in sterile technique, RN M confirmed sterile technique was not maintained and verbalized frustration related to issues with the (dressing change) kit. When asked why they removed the StatLock device with clean gloves, as they touched the PICC line insertion site at that time, RN M validated they did and revealed they followed the order provided in their facility policy/procedure. RN M provided a Validation Checklist: PICC. Dressing Change list. The procedure included the numbered steps, 10. Opened sterile dressing change kit and laid out items using sterile technique. 11. Performed hand hygiene and donned clean gloves. 12. Removed old dressing. 14. Removed stabilization device. 16. Removed gloves, performed hand hygiene, and donned sterile gloves. 17. Measured external length of catheter from hub to skin entry. 18. Cleansed area with antiseptic solution. 21. Secured catheter with stabilization device. 22. Applied transparent semipermeable dressing to insertion site. The procedure provided did not identify measuring the circumference of the arm. An interview was completed with the Director of Nursing (DON) on 9/12/25 at 11:52 AM. When queried regarding Resident #2's PICC line dressing change and identified concerns, the DON revealed they were aware and did not have any questions. According to the Infusion Nurses Society (INS) Infusion Therapy Standards of Practice, Section Six: Vascular Access Device Management. 38. Flushing and Locking Practice Recommendations. 1. Use a single-use prefilled 0.9% sodium chloride syringe to slowly aspirate the (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	VAD for free-flowing blood return that is the color and consistency of whole blood, an important component of assessing catheter function. F. Use positive-pressure techniques to minimize blood reflux into the VAD lumen. 3. Use a gentle pulsatile flushing technique to deliver flush into the catheter. G. Lock short and long PIVCs and midline catheters immediately following each use. 39. Vascular Access Device Post-Insertion Care. a. Remove nontransparent dressing to visually inspect site if patient has local tenderness or other signs of possible local infection; otherwise, use palpation for assessment. b. Measure the external vascular access device (VAD) length at each dressing change. c. Measure circumference of the extremity and compare to baseline measurement when clinically indicated to assess the presence of edema and possible catheter-associated deep vein thrombosis (blood clot) . I. Prepare skin for optimal skin health and dressing adherence. 1. Remove dressing and adhesive-based securement device, maintaining skin integrity and preventing VAD (Vascular Access Device) dislodgement. Use sterile gloves if there is a need to touch the insertion site. (2024, p. 137-149). Review of facility provided policy revealed, Care and Maintenance of Central Venous Catheter (Reviewed/Revised: 12/13/23) revealed, The facility will adhere to accepted standards of practice regarding the care and maintenance of central venous catheters. 4. Wear sterile gloves for dressing changes.Reference:Nickel, B., [NAME], L., [NAME], T., [NAME], A., [NAME], M., [NAME], S., [NAME], B., [NAME], M. J., Crickman, R., Ong, J., [NAME], S., & [NAME], M. E. (2024). Infusion Therapy Standards of Practice, 9th Edition. Journal of infusion nursing: the official publication of the Infusion Nurses Society, 47(1S Suppl 1), S1-S285. https://doi.org/10.1097/[NAME].0000000000000532

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that respiratory care and oxygen therapy administration tubing was changed per Health Care Provider's (HCP) order for one resident (Resident #2) of one resident reviewed.Findings include:Resident #2:On 9/10/25 at 10:14 AM, A Contact Precaution sign was observed on Resident #2's room door. The Resident's door was open and they were laying in bed, on their back with their eyes closed. Resident #2 had supplement oxygen in place via nasal cannula (NC). Activity Aide S and Certified Nursing Assistant (CNA) T were observed in the hallway. When asked the reason Resident #2 had contact precautions in place, Activity Aide S verbalized they did not know and CNA T stated, (Resident #2) has a central line (PICC). When asked if the Resident had an infection, CNA T replied, No. On 9/11/25 at 8:20 AM, Resident #2 was observed in their room, sitting on the edge of their bed. The Resident's NC prongs (part of the tubing that oxygen comes out of and is supposed to be positioned in the nose) were positioned on the Resident's cheek and not in their nose. When asked about the position of their oxygen tubing, Resident #2 stated, Must have came out (of nose) when brushing hair. When queried, Resident #2 revealed they did not wear oxygen at home but have been wearing it around the clock at the facility. An observation of the oxygen concentrator revealed the oxygen administration rate was set at 2.5 Liters (L) per minute (min). The oxygen tubing had a sticker on it with the date, 8/24 on it. Record review revealed Resident #2 was most recently admitted to the facility on [DATE] with diagnoses which included infection, rheumatoid arthritis (RA), Post Traumatic Stress Disorder (PTSD), and Chronic Obstructive Pulmonary Disease (COPD). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required set-up to substantial assistance to complete all Activities of Daily Living (ADLs).Review of Resident #2's Electronic Medical Record (EMR) revealed a care plan entitled, Resident has an impaired pulmonary/respiratory status related to COPD/Sleep apnea/chronic respiratory failure. frequently removes oxygen (Initiated: 8/15/25; Revised: 8/27/25). The care plan included the interventions:- Oxygen as ordered (Initiated: 8/15/25)- Provide oxygen as needed when resident exhibits signs/symptoms of difficulty breathing (Initiated: 8/27/25) Review of Resident #2's Health Care Provider Orders revealed the following orders:- Oxygen: RUN @ 2L (liters) NC (Nasal Cannula) at Noc (chronic) every night shift for Sleep Apnea, COPD (Start Date: 8/15/25)- Oxygen tubing/filter change every week via (external company) on Mondays (Start Date: 8/15/25) An observation of Resident #2's oxygen tubing was completed on 9/11/25 at 3:10 PM with Registered Nurse (RN) M and Licensed Practical Nurse (LPN) U. When queried how often oxygen tubing is supposed to be changed, both RN M and LPN U responded that oxygen tubing is supposed to be changed weekly by the external respiratory supply company that comes to the facility. When asked why the Resident's oxygen tubing was dated 8/24 if it is supposed to be changed weekly, both staff verbalized that the external company must not have changed it. With further inquiry, RN M specified that nursing staff should also check the oxygen tubing. An interview was completed with the Director of Nursing (DON) on 9/12/25 at 11:52 AM. When queried if oxygen should be administered per HCP orders, the DON verbalized it should. When asked how often oxygen tubing should be changed, the DON responded that it is changed weekly. When asked why Resident #2's oxygen tubing was dated 8/24/25 if it is supposed to be changed weekly, the DON did not provide further explanation. Review of facility policy/procedure entitled, Oxygen Administration (Reviewed/Revised: 10/26/23) revealed, Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences. 5. Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include: a. Follow manufacturer recommendations for the frequency of cleaning equipment filters. b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure that the appropriate backflow prevention was installed on cross connections. This deficient practice increases the likelihood of contamination of the water supply due to a backflow event, potentially affecting all residents, staff, and visitors who consume water at the facility.Findings include: On 09/10/2025 at 10:30AM during the kitchen tour, observed overhead spray nozzle sitting below the flood rim in the garbage disposal. During interview at this time with Certified Dietary Manager G, she stated she was just using it and forgot to put it back on the hook. On 09/10/2025 1:30PM - 2:30PM during interview with Regional Maintenance I, he stated they are in the process of replacing the sink and the overhead spray nozzle in the kitchen and proceeded to show the order for the parts. On 09/10/2025 between 1:30PM - 2:25PM observed a hose with a spray nozzle attached downstream of a hose bib atmospheric vacuum breaker on the outside spigot located near the front of the building. At this time, Regional Maintenance I was observed to remove the spray nozzle. On 09/10/2025 1:30PM - 2:30PM observed a hose with an attached spray nozzle downstream of a hose bib atmospheric vacuum breaker on the outside spigot located near the dining room/patio area. Observed Regional Maintenance I remove the spray nozzle from the hose. During interview at this time with Maintenance Director H and Regional Maintenance I, they stated that normally the hoses do not have the spray nozzle attached. According to the 2022 Food Code, 5-202.13 Backflow Prevention, Air Gap, An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or non-food equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch).According to the 2008 Cross Connection Manual on atmospheric vacuum breakers, AVBs shall not be installed where they will be under continuous pressure for more than 12 hours (i.e. no downstream shutoff valve).