STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265324	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Manor Nursing Center	100 Woodland Court Arnold, MO 63010

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure staff treated residents with dignity and in a respectful manner by leaving one resident (Resident #134) out of five sampled residents exposed during wound care. The census was 126. Review of the facility's policy titled, Resident Privacy/Dignity/Customer Service, not dated, showed:- Staff will knock on doors before entering a resident's room or ask permission before entering behind curtains and wait for a reply before opening the curtains;- Staff will close curtains completely, window and doors fully during care;- Residents will not be exposed in an embarrassing manner. 1. Review of Resident #134's medical record showed:- An admission date of 11/17/25;- Diagnoses of chronic obstructive pulmonary disease (COPD - a lung disease), diabetes mellitus (DM - a condition that affects the way the body processes blood sugar), chronic kidney disease (gradual loss of kidney function over time), anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), constipation, and obstructive sleep apnea (a disorder where breathing repeatedly stops and starts during sleep due to throat muscles relaxing and blocking the airway). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 03/04/26, showed:- Cognition intact;- Dependent on staff for dressing, bed mobility, transfers, and toileting;- Always incontinent of bladder and bowel;- Moisture associated skin damage (MASD - skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, or wound drainage). Observation of the resident on 03/25/26 at 11:16 A.M. through 11:39 A.M., showed:- Registered Nurse (RN) J and Certified Nurse Aide (CNA) K entered the room to perform wound care;- RN J closed the door, no curtain available to close for the resident's privacy, and started performing wound care; - At 11:19 A.M., RN J opened the door to retrieve more supplies from a treatment cart and left the door open for several minutes with the resident's buttocks exposed and visible from the hallway; - RN J returned to the room, closed the door, and continued with the resident's wound care;- At 11:26 A.M., RN J opened the door to retrieve more supplies from a treatment cart, left the door open for several minutes with the resident's buttocks exposed and visible from the hallway, and two CNAs walked by the room and looked in; - RN J returned to the room, closed the door, and continued with the resident's wound care;- At 11:28 A.M., RN J opened the door to retrieve more supplies from a treatment cart and left the door open for several minutes with the resident's abdomen exposed and visible from the hallway; - RN J and CNA K failed to provide privacy during wound care for the resident. During an interview on 03/26/25 at 10:15 A.M., RN J said the resident's door should remain closed during wound care for a resident's privacy. During an interview on 03/27/26 at 11:14 A.M., the Director of Nursing (DON) said she would expect staff to always protect a resident's privacy during wound care by pulling the curtain or closing the door. During an interview on 03/30/26 at 9:55 A.M., the Administrator said he would expect a resident's privacy to be protected during wound care.

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to inform residents and/or their responsible parties, in advance of the risks and benefits of proposed care, before beginning psychotropic (medications that affect the mind, emotions, and behavior) medications for nine residents (Residents #2, #6, #7, #10, #24, #37, #67, #104, and #123) out of nine sampled residents. The facility census was 126. Review of the facility policy titled, Medication Policy and Procedure, dated 02/15/18, showed: - Psychotropic medications include antianxiety, hypnotic (induces sleep), and antipsychotic (medications used to treat psychosis symptoms such as delusions, hallucinations, and paranoia, by regulating brain chemicals) medications; - The physician or psychiatrist will document the discussion with the resident and/or responsible party regarding the risk versus the benefit of the use of medication, including off label use of the medication. 1. Review of Resident #2's medical record showed: - An admission date of 07/14/24; - Diagnoses of major depressive disorder (MDD - a serious mental health condition characterized by at least two weeks of persistent, pervasive low mood, loss of interest, and low self-esteem), anxiety disorder (excessive, persistent fear or worry that interferes with daily life), and bipolar disorder (mood disorder that can cause intense mood swings); - An order for olanzapine (an antipsychotic medication) 5 milligrams (mg) by mouth two times a day, dated 11/26/25; - An order for buspirone (an antianxiety medication) 15 mg by mouth three times a day, dated 11/26/25; - An order for sertraline (an antidepressant medication) 125 mg by mouth one time per day, dated 12/03/25; - No documentation of consent or education of risks and benefits for the olanzapine, buspirone, and sertraline use was provided to the resident and/or their representative. 2. Review of Resident #6's medical record showed: - An admission date of 07/31/25; - Diagnoses of cerebral infarction (stroke) and moderate protein-calorie malnutrition (nutrition problem leading to health issues or weight loss); - An order for mirtazapine (an antidepressant medication also used to stimulate appetite) 7.5 mg by mouth once a day at night, dated 12/05/25; (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation of consent or education of risks and benefits for the mirtazapine use was provided to the resident and/or their representative. 3. Review of Resident #7's medical record showed: - An admission date of 02/14/25; - Diagnoses of generalized anxiety disorder and MDD; - An order for bupropion (an antidepressant medication) 200 mg by mouth every 12 hours for MDD, dated 12/01/25; - An order for clonazepam (an antianxiety medication) 0.5 mg by mouth every 12 hours for generalized anxiety disorder, dated 09/09/25; - An order for escitalopram (an antidepressant medication) 10 mg by mouth upon rising for MDD, dated 01/10/26; - No documentation of consent or education of risks and benefits for the buproprion, clonazepam, and escitalopram use was provided to the resident and/or their representative. 4. Review of Resident #10's medical record showed: - An admission date of 08/04/25; - Diagnoses of MDD, anxiety disorder, suicidal ideations (thinking about, considering, or planning suicide, ranging from fleeting thoughts to detailed, active plans), and post-traumatic stress disorder (PTSD - a mental health condition triggered by experiencing or witnessing terrifying, life-threatening, or traumatic events); - An order for duloxetine (an antidepressant medication) 60 mg by mouth upon rising, dated 01/08/26; - No documentation of consent or education of risks and benefits for the duloxetine use was provided to the resident and/or their representative. 5. Review of Resident #24's medical record showed: - An admission date of 10/30/25; - Diagnosis of MDD; - An order for sertraline 50 mg by mouth once a day, dated 01/16/26; - An order for buproprion extended release (XL) 300 mg by mouth once a day, dated 01/16/26; - No documentation of consent or education of risks and benefits for the sertraline and buproprion use (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was provided to the resident and/or their representative. 6. Review of Resident #37's medical record showed: - An admission date of 03/06/26; - Diagnoses of anxiety and restless leg syndrome; - An order for hydroxyzine (used to treat anxiety) 50 mg 0.5 tablet by mouth every six hours as needed for anxiety, dated 03/06/26, with no stop date; - An order for clonazepam 0.25 mg by mouth in morning, dated 03/07/26; - An order for buspirone 5 mg by mouth three times a day, dated 03/06/26; - No documentation of consent or education of risks and benefits for the hydroxyzine, clonazepam, and buspirone use was provided to the resident and/or their representative. 7. Review of Resident #67's medical record showed: - An admission date of 03/07/26; - Diagnoses of dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), psychophysical visual disturbances (visual impairments), and depression; - An order for venlafaxine (an antidepressant medication) 37.5 mg by mouth once a day in the morning, dated 03/08/26; - No documentation of consent or education of risks and benefits for the venlafaxine use was provided to the resident and/or their representative. 8. Review of the Resident #104's medical record showed: - An admission date 03/04/26; - Diagnoses of dementia, bipolar disorder, and unspecified psychosis (a mental disorder with a severe loss of contact with reality); - An order for fluoxetine (an antidepressant) 40 mg by mouth upon rising, dated 03/04/26; - An order for lamotrigine (an antiseizure medication also used to treat bipolar disorder) 200 mg by mouth at bedtime, dated 03/04/26; - No documentation of consent or education of risks and benefits for the fluoxetine and lamotrigine use was provided to the resident and/or their representative. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9. Review of Resident #123's medical record showed: - An admission date of 01/08/22; - Diagnosis of MDD; - An order for duloxetine 30 mg by mouth one time per day, dated 02/19/26; - No documentation of consent or education of risks and benefits for the duloxetine use was provided to the resident and/or their representative. During an interview on 03/27/26 at 1:42 P.M., the Director of Nursing (DON) said she would expect residents to have informed consent for psychotropic medications. During an interview on 03/30/26 at 9:59 A.M., the Administrator said he would expect residents to be informed of risks and benefits of psychotropic medications

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to issue a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) to the resident and/or the resident's representative in writing at least two calendar days before discharge from skilled services. This notice informs the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting the financial liability for those services. This practice affected one resident (Resident #13) out of three sampled residents. The facility census was 126. Review of the facility's policy titled, Medicare Coverage Notification, revised 01/17/18, showed:- When resident's Medicare coverage is coming to an end, the social services designee (SSD) is required to give at least a 72-hour notice of non-coverage to the resident and/or responsible party;- A SNF ABN is provided at least three days prior to discharge and signed by the resident and/or responsible party upon notice of non-coverage if the resident is discharging from Medicare services and remain in facility. 1. Review of Resident #13's medical record showed:- The resident discharged from skilled Medicare services on 11/05/25, and remained in the facility;- The resident's representative received a SNF ABN on 11/04/25;- The facility failed to provide the SNF ABN form to the resident and/or the representative at least two calendar days before the skilled Medicare services ended. During an interview on 03/26/26 at 9:07 A.M., the Director of Social Services said the SNF ABN should have been provided at least two days prior to the last day covered by Medicare. During a phone interview on 03/30/26 at 9:55 A.M., the Administrator said the SNF ABN form should have been provided to the resident and/or the representative at least two days prior to the end of the Medicare coverage.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable and homelike environment. The deficient practice had the potential to affect all residents. The facility's census was 126.Review of the facility's policy titled, Homelike Environment, revised 02/13/21, showed:- Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible;- The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized homelike setting to include a clean, sanitary and orderly environment. Observation on 03/24/26 at 12:30 P.M., of the shower room located at the end of the 100 Hall showed:- The door propped open;- A 4 inch (in.) by 12 in. piece of tile trim missing at the base of the door entry;- A white, plastic shower curtain with a 2 in. by 2 in. brown stain near the top, torn in half, and the bottom half lay in the shower room floor and three hooks missing at the top which caused it to droop;- A 24 in. by 2 in. area of peeling ceiling paint located in the shower room on the left;- A 6 in. by 3 in. area of peeling ceiling paint and a 1 in. by 1 in. hole in the ceiling located in the shower room on the right;- A wheelchair seat cushion lay on the shower floor;- A toilet full of a dark brown liquid with a foul odor;- A toilet seat with stained areas and cracked, peeling areas;- A walker folded up to the right side of the toilet;- Three wheelchair leg rest/foot pedals located on a wire shelf above the left side of the toilet. Observation on 03/25/26 at 8:30 A.M., of the shower room located at the end of the 100 Hall showed:- The door propped open;- A 4 in. by 12 in. piece of tile trim missing at the base of the door entry;- A white, plastic shower curtain with a 2 in. by 2 in. brown stain near the top, torn in half, and the bottom half lay in the shower room floor and three hooks missing at the top which caused it to droop;- A 24 in. by 2 in. area of peeling ceiling paint located in the shower room on the left;- A 6 in. by 3 in. area of peeling ceiling paint and a 1 in. by 1 in. hole in the ceiling located in the shower room on the right;- A pair of soiled pants lay on the floor; - Three wheelchair leg rest/foot pedals located on a wire shelf above the left side of the toilet. Observation on 03/26/26 at 2:20 P.M., of the shower room located at the end of the 100 Hall showed:- The door propped open;- A 4 in. by 12 in. piece of tile trim missing at the base of the door entry;- A white, plastic shower curtain with a 2 in. by 2 in. brown stain near the top, torn in half, and the bottom half lay in the shower room floor and three hooks missing at the top which caused it to droop;- A 24 in. by 2 in. area of peeling ceiling paint located in the shower room on the left;- A 6 in. by 3 in. area of peeling ceiling paint and a 1 in. by 1 in. hole in the ceiling located in the shower room on the right;- A pillow and two wheelchair seat cushions lay on the floor beside the left side of the toilet;- A 2 in. by 3 in. area of brown splatter on the wall to the right side of the toilet;- Three wheelchair leg rest/foot pedals located on a wire shelf above the left side of the toilet;- A plugged-in hairdryer lay in the sink;- An opened bottle of aftershave liquid without a lid sat on the sink. During an interview on 03/27/26 at 10:50 A.M., Certified Nurse Aide (CNA) E said there were two shower rooms on the 100 Hall and staff used both. The shower curtain had been torn for a month or two. If something needed to be fixed or replaced, staff filled out a work order and placed it in the plastic box on the wall. During an interview on 03/27/26 at 10:55 A.M. the Maintenance Director said staff notified him if things need fixed or replaced by filling out work orders and putting them in the box hung on the walls of each hall. He checked the boxes three times a day. During an interview on 03/27/26 at 1:45 P.M., the Director of Nursing (DON) said she would expect shower rooms to be in good repair and to have shower curtains not torn.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a transfer and/or discharge to a hospital, including the reason for the transfer for seven residents (Residents #2, #4, #6, #8, #27, #68, and #73) out of 12 sampled residents. The facility's census was 126. Review of the facility policy titled, Discharge Procedures, undated, showed: - Before transfer or discharge, the facility shall send written notification to the resident in a language and manner reasonable calculated to be understood by the resident; - The notice must also be sent to any legally authorized representative of the resident and to at least one family member; - A copy of the notice will be forwarded to the Department of Health and Senior Services regional office and the regional coordinator of the Missouri State Ombudsman's (advocate for the resident in nursing facilities) office; - The written notice should include the reason for transfer or discharge, the effective date of transfer or discharge, and the location to which the resident is being transferred or discharged . 1. Review of Resident #2's medical record showed: - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - No documentation the resident or resident's representative was informed in writing of the transfers and included the reason for the transfers. 2. Review of Resident #4's medical record showed: - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - No documentation the resident or resident's representative was informed in writing of the transfer and included the reason for the transfer. 3. Review of Resident #6's medical record showed: - Transferred to hospital on [DATE], and returned to the facility on [DATE]; - Transferred to the hospital on [DATE], and returned to the facility on [DATE]; (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation the resident or resident's representative was informed in writing of the transfers and included the reason for the transfers. 4. Review of Resident #8's medical record showed: - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; -The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - No documentation the resident or resident's representative was informed in writing of the transfers and included the reason for the transfers. 5. Review of Resident #27's medical record showed: - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - No documentation the resident or resident's representative was informed in writing of the transfers and included the reason for the transfers. 6. Review of Resident #68's medical record showed: - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - No documentation the resident or resident's representative was informed in writing of the transfers and included the reason for the transfers. 7. Review of Resident #73's medical record showed: - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE], and returned to the facility on [DATE]; - The resident transferred to the hospital on [DATE]; (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation the resident or resident's representative was informed in writing of the transfers and included the reason for the transfers. During an interview on 03/27/26 at 10:18 A.M., Licensed Practical Nurse (LPN) G said he/she was unaware of any official transfer form. During an interview on 03/27/26 at 10:57 A.M., the Social Services Designee (SSD) said he/she filled out the Bed Hold notice and mailed it to the resident's responsible party, but he/she did not fill out the transfer notices. It was the responsibility of the nurse transferring the resident to the hospital. During an interview on 03/27/26 at 2:00 P.M., the Director of Nursing (DON) said nurses were responsible to complete the transfer sheets at time of the transfer and she would expect them to be completed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to document a complete and accurate Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) for four residents (Residents #10, #24, #67, and #104) out of 25 sampled residents. The facility's census was 126. Review of the facility policy titled, MDS Policy and Procedure, dated 02/22/22, showed: - The resident interview must be completed by the MDS coordinator or other specialized disciplines; - A comprehensive review of the resident's medical record will be completed; - Once the resident and staff interviews are completed and the medical record is reviewed, the MDS assessment section may be completed as detailed in the Resident Assessment Instrument (RAI) Manual (the official, comprehensive guide for nursing homes on how to use the RAI system to assess resident care needs). Review of the RAI Manual, Version 3.0, dated October 2024, showed: - Section A1500: Preadmission Screening and Resident Review (PASRR - a federally mandated screening process for individuals with serious mental illness and/or intellectual disability/developmental disability related diagnosis) should be marked Yes (or coded one) if PASRR Level II screening determined that the resident has a serious mental illness and/or intellectual developmental disability or related condition; - Section I: Active diagnoses are defined as physician documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nurse monitoring, or risk of death during the seven-day look-back period; - Section N0415: High-Risk Drug Classes Used and Indication should be marked yes if the resident is taking any medications by pharmacological classification during the last seven days and checked if there is an indication noted for all medications in the drug class; - Section O0110: Special Treatments, Procedures, and Programs should be checked for any treatment, procedure, and program performed within the last 14 days. 1. Review of Resident #10's medical record showed: - An admission date of 08/04/25; - Diagnoses of major depressive disorder (MDD - a serious mental health condition characterized by at least two weeks of persistent, pervasive low mood, loss of interest, and low self-esteem), anxiety disorder (characterized by excessive, persistent fear or worry that interferes with daily life), and post-traumatic stress disorder (PTSD - a mental health condition triggered by experiencing or witnessing terrifying, life-threatening, or traumatic events). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's PASRR, dated 08/13/25, showed: - Resident with a serious mental illness. Review of the resident's admission MDS, dated [DATE], showed: - The resident was not considered by the state level II process to have a serious mental illness and/or intellectual disability or a related condition. 2. Review of Resident #24's medical record showed: - An admission date of 10/30/25; - Diagnosis of myelofibrosis (type of bone cancer); - Had a port (medical device to deliver medications) with weekly chemotherapy (treatments for cancer). Review of the resident's quarterly MDS, dated [DATE], showed: - No diagnosis of cancer; - Did not receive chemotherapy. 3. Review of Resident #67's medical record showed: - An admission date of 03/07/26; - Diagnoses of thrombophilia (a condition causing blood to clot easily), atrial fibrillation (abnormal heart beat), heart disease (heart does not pump as it should), chronic kidney disease, depression, chronic obstructive pulmonary disease (COPD - lung disease), obstructive sleep apnea (breathing issues because compromised airway that causes breathing issues during sleep), and cardiac pacemaker (a medical device to help the heart to function); - An order for warfarin (an anticoagulant medication) 3 milligram (mg) 0.5 by mouth with the evening meal on 03/27/26; - An order for furosemide (a diuretic medication) by mouth every morning, dated 03/08/26; - An order for venlafaxine (an antidepressant medication) 37.5 mg by mouth every day in the morning with breakfast, dated 03/08/26; - An order for oxygen at 2 liters per minute by nasal cannula (device used to deliver oxygen with two small tubes that fit into the nostrils) continuously, dated 03/07/26; (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for bilevel positive airway pressure (BiPAP – a machine to assist with breathing) every shift with settings 14 over 8 with 2 liters of oxygen bleed in while sleeping, dated 03/07/26. Review of the resident's admission MDS, dated [DATE], showed: - No diagnoses for renal failure and depression; - Did not receive anticoagulant; - No for BiPAP and non-invasive mechanical ventilation used. 4. Review of Resident #104's medical record showed: - An admission date of 03/04/26; - Diagnoses of cellulitis (skin infection) right lower limb and left foot osteomyelitis (bone infection); - An order for ceftriaxone (an antibiotic medication) 2 grams intravenous (IV - administered into the vein) with lunch for 20 days, dated 03/29/26; - An order for peripherally inserted central catheter (PICC – tube/catheter inserted into a vein for medication administration) line dressing change every 7 days every morning shift. Catheter length was 51 centimeters (cm) with single lumen (opening in the catheter), dated 03/11/26. Review of the resident's admission MDS, dated [DATE], showed: - Did not receive IV medications. During an interview on 03/27/26 at 3:15 P.M., the MDS Coordinator said he/she gathered the information from the residents' medical records such as the care plan, progress notes, and orders, and talked to the staff. If it was not mentioned during those reviews, then it would not be coded on the MDS. During an interview on 03/30/26 at 9:55 A.M., the Administrator said he would expect the MDS to accurately reflect the resident's condition at the time of the assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop and implement an individualized comprehensive care plan with specific interventions to meet the highest practicable physical, mental, and psychosocial well-being for four residents (Residents #6, #37, #67, and #104) out of 25 sampled residents. The facility's census was 126.Review of the facility policy titled, Care Plan Section Responsibility, undated, showed:- Objective was to ensure individualized completion of the care plan, and family /resident participation in the resident's plan of care with admission, quarterly, annual update, and if there is a significant change of condition;- The care plan must be based upon the resident assessment, choices and advancedirectives, if any. As the resident's status changes, the facility, attending practitionerand the resident representative, to the extent possible, must review and/or revise care plan goals and treatment choices. 1. Review of Resident #6's medical record showed:- An admission date of 07/31/25;- Diagnosis of benign prostatic hyperplasia (BPH - an enlargement of the prostate causing difficulty in urination) without lower urinary tract symptoms;- An order for suprapubic (a thin, flexible tube inserted into the bladder through a small incision in the lower abdomen) catheter care every shift to clean with normal saline and pat dry, apply a drain sponge and tape in place, dated 03/26/26;- An order to monitor the urinary catheter output each shift, dated 11/11/25. Review of the resident's care plan, last reviewed 02/13/26, showed:- Did not address the suprapubic catheter, the care, and the monitored output with goals and interventions. 2. Review of Resident #37's medical record showed:- An admission date of 03/06/26;- Diagnoses of Ogilvie syndrome (condition of colon dilation without mechanical blockage) and ileostomy (a surgical procedure where the intestine goes through an opening in the abdominal area to allow waste to come out). Review of the resident's care plan, last reviewed 03/13/26, showed:- Did not address the ileostomy with goals and interventions. 3. Review of Resident #67's medical record showed:- An admission date of 03/07/26;- Diagnoses of thrombophilia (a condition causing blood to clot easily), atrial fibrillation (an abnormal heart beat), heart disease (the heart does not pump as it should), dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), and a cardiac pacemaker (medical device to help the heart function);- An order for prothrombin time (PT - evaluates the ability of the blood to clot properly, used to help diagnose bleeding)/international normalized ratio (INR - used to monitor the effectiveness of blood thinning drugs) on 03/27/26;- An order for warfarin (a blood thinner) 3 milligrams (mg) 0.5 tablet by mouth with the evening meal on 03/27/26. Review of the resident's care plan, last reviewed 03/14/26, showed:- Did not address the anticoagulant medication and the lab orders for the titration of the dose with goals and interventions;- Did not address the cardiac pacemaker with goals and interventions;- Did not address dementia and care with goals and interventions. 4. Review of the Resident #104's medical record showed:- An admission date 03/04/26;- Diagnoses of cellulitis (skin infection) right lower limb, atrial fibrillation, diabetes mellitus (DM - a condition that affects the way the body processes blood sugar), dementia, bipolar (a mental disorder that causes unusual shifts in mood), obstructive sleep apnea (an airway issue causing breathing to stop for periods of time during sleep), chronic obstructive pulmonary disease (COPD - a lung disease), heart failure (the heart does not function as it should), and asthma (a lung condition making it more difficult to breathe);- An order for ceftriaxone (an antibiotic medication) 2 grams intravenously (IV - administered into a vein) with lunch for 20 days, dated 03/29/26;- An order for metronidazole (an antibiotic medication) 500 mg by mouth every 12 hours for 20 days, dated 03/29/26;- An order for doxycycline (an antibiotic medication)100 mg by mouth every 12 hours for 20 days, dated 03/29/26;- An order for bilevel positive airway pressure (BiPAP - a machine to assist with breathing) machine to use every shift at times of rest and at night. BiPAP instructions were nasal mask with settings of peak inspiratory pressure (highest level of pressure applied to the lungs) of 22 and expiratory positive airway pressure (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(low pressure applied to the lungs) of 18 with a set breathing back up rate of 10 breaths per minute. Keep oxygen saturation (percent of oxygen in the blood) of 92 percent or greater, dated 03/04/26;- An order for BiPAP every Sunday morning shift to wash the mask/tubing and headgear with mild soap and water, allow to air dry, dated 03/04/26;- An order for albuterol sulfate (a bronchodilator medication used to open the airways) hydrofluoroalkane (HFA - a propellant in an inhaler) 90 microgram (mcg)/actuation 2 HFA aerosol inhaler inhalations every 6 hours as needed for shortness of breath, dated 03/04/26;- An order for peripherally inserted central catheter (PICC - tube/catheter inserted into a vein for medication administration) line dressing change every 7 days every morning shift. Catheter length was 51 centimeters (cm) with single lumen (opening in the catheter), dated 03/11/26;- An order for insulin lispro (a medication to treat DM) subcutaneous (beneath the skin) pen per sliding scale with meals for a blood sugar of 0 - 140 = 0 units, 141 - 180 = 2 units, 181 - 220 = 4 units, 221 -260 = 6 units, 261 - 300 = 8 units, 301 - 350 = 10 units, and for greater than 351 give 12 units and call physician, dated 03/04/26;- An order for Toujeo Max (a medication for DM) subcutaneous insulin pen 40 units subcutaneous in the morning, dated 03/04/26- An order for Eliquis (a blood thinning medication) 5 mg by mouth every 12 hours, dated 03/04/26. Review of the resident's care plan, last reviewed 03/11/26, showed:- Did not address the PICC line and care with goals and interventions;- Did not address antibiotics related to wounds and infection and care with goals and interventions;- Did not address the respiratory needs of the medications, oxygen, BiPAP, and care with goals and interventions;- Did not address DM, medications, and care with goals and interventions;- Did not address the blood thinning medication and care with goals and interventions;- Did not address dementia and care with goals and interventions. During an interview on 03/27/26 at 1:50 P.M, the Director of Nursing (DON) said he/she would expect the care plan to accurately reflect the resident's current condition. The care plan should be revised as needed with resident changes. During an interview on 03/27/26 at 3:40 P.M., the Pavillion Nurse Manager said he/she worked on the care plans. Residents with indwelling devices, oxygen, BiPAP, and antibiotics should be on the care plan. Care plans should be revised as needed with changes to accurately reflect the resident's condition. During an interview on 03/30/26 at 9:55 A.M., the Administrator said he would expect the care plan to accurately reflect the resident's current condition.

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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 a physician's order for oxygen use and oxygen tubing care was obtained for two residents (Residents #27 and #40) and the facility also failed to follow physician's orders for oxygen use for three residents (Residents #8, #81, and #123) out of 12 sampled residents. The facility census was 126.Review of the facility policy titled, Physician's Orders, undated, showed: - Orders received by the physician are to be followed as prescribed. Review of the facility policy titled, Oxygen Storage/Use, undated, showed: - Oxygen tubing is to be bagged when not in use; - Did not address when to change the oxygen tubing. 1. Review of Resident #8's medical record showed: - admitted on [DATE]; - Diagnoses of chronic obstructive pulmonary disease (COPD – a lung disease) and malignant neoplasm (cancerous tumor) of the upper right and left lung and of the lower right and left lung. Review of the resident's March 2026 physician order sheet (POS), showed: - An order for oxygen at 2 liters per minute (LPM) via nasal canula (NC – a device used to deliver oxygen with two small tubes that fit into the nostrils) every shift, dated 07/13/24. Review of the resident's care plan, review date of 03/04/26, showed: - Resident receives oxygen therapy related to medical diagnosis, as evidenced by use of oxygen with interventions of: Observe for signs/symptoms of respiratory distress, oxygen to be provided via nasal cannula or mask at the LPM prescribed by physician; Staff to provide the oxygen concentrator, tubing, tank, etc; Tubing/mask to be changed weekly and as needed (PRN). Observation of the resident on 03/24/26 at 12:00 P.M., showed: - The resident sat in his/her wheelchair in his/her room with oxygen on at 3 LPM via an undated NC per the oxygen concentrator; - An oxygen canister attached to the wheelchair, not in use, and an undated NC not stored in a storage bag. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the resident on 03/25/26 at 2:35 P.M., showed: - The resident lay in bed with oxygen at 3 LPM via an undated NC per the oxygen concentrator; - An oxygen canister attached to the wheelchair, not in use, and an undated NC not stored in a storage bag. During an interview on 03/24/26 at 12:00 P.M., the resident said his/her oxygen should be set at 2 LPM and not 3 LPM, and staff changed his/her NC, but he/she was not sure of how often. 2. Review of Resident #27's medical record showed: - admitted on [DATE]; - Diagnoses of COPD, chronic atrial fibrillation (an irregular heart rhythm), and pneumonia (infection and inflammation of the lung). Review of the resident's March 2026 POS showed: - No order for oxygen administration. Review of the resident's care plan, review date of 03/04/26, showed: - Resident receives oxygen therapy related to medical diagnosis with interventions of: Monitor oxygen saturations (percent of oxygen in the blood) as needed, observe for signs and symptoms of respiratory distress, oxygen to be provided via nasal cannula or mask at rate prescribed by physician; Staff to provide oxygen concentrator, tubing, tank, etc.; Tubing/mask to be changed weekly and PRN; Maintain oxygen saturation at 90% or greater with oxygen use as ordered by the physician. Observation of the resident on 03/24/26 at 12:15 P.M., showed: - The resident lay in bed with oxygen on at 3 LPM via an undated NC per the oxygen concentrator. 3. Review of Resident #40's medical record showed: - An admission date of 01/08/22; - Diagnoses of COPD and dependence on supplemental oxygen. Review of the resident's March 2026 POS showed: - No order for oxygen administration. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, review date of 03/04/26, showed: - Resident receives oxygen therapy related to medical diagnosis with interventions of: Monitor oxygen saturations as needed, observe for signs and symptoms of respiratory distress, oxygen to be provided via nasal cannula or mask at rate prescribed by physician; Staff to provide oxygen concentrator, tubing, tank, etc.; Tubing/mask to be changed weekly and PRN; Maintain oxygen saturation at 90% or greater with oxygen use as ordered by the physician. Observation of the resident on 03/24/26 at 11:51 A.M., showed: - The resident sat in his/her wheelchair in his/her room with oxygen on at 3 LPM via an undated NC per the oxygen concentrator. Observation of the resident on 03/26/26 at 2:38 P.M., showed: - The resident sat in his/her wheelchair in his/her room with oxygen on at 4.5 LPM via an undated NC per the oxygen concentrator. Observation of the resident on 03/27/26 at 6:36 A.M., showed: - The resident sat in his/her wheelchair with no oxygen via NC; - The undated NC lay on the floor and not in a storage bag. 4. Review of Resident #81's medical record showed: - An admission date of 12/01/12; - Diagnoses of chronic pulmonary edema (fluid builds up in the lungs), heart failure, shortness of breath, and asthma (a lung disease). Review of the resident's March 2026 POS showed: - An order for oxygen 2 LPM via NC PRN for shortness of breath, may titrate to maintain saturations above 90%, notify physician if saturations are less than 90%, dated 01/29/25. Review of the resident's care plan, review date of 03/04/26, showed: - Continuous oxygen related to asthma with interventions of: Administer medication, respiratory treatments, and oxygen as ordered; Monitor for worsening cough, decreased lung sounds or temperature; Monitor lung sounds, pallor (unnatural skin color), cough, and character of sputum; Monitor respiratory rate and effort. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of the resident on 03/24/26 at 11:34 A.M., and 03/27/26 at 10:01 A.M., showed: - The resident sat in his/her wheelchair in his/her room with oxygen on at 3 LPM via an undated NC per the oxygen concentrator; - An oxygen canister attached to the wheelchair, not in use, with an undated NC wrapped around the left wheelchair arm rest and not stored in a storage bag. Observation of the resident on 03/26/26 at 2:36 P.M., showed: - The resident sat in his/her wheelchair in the hallway with oxygen on at 3 LPM via undated NC per an oxygen canister. During an interview on 03/24/26 at 11:34 A.M., the resident said he/she always required oxygen. The staff did not change the NC, but he/she had extra NCs and could change it. 5. Review of Resident #123's medical record showed: - An admission date of 01/08/22; - Diagnoses of COPD and acute onset chronic respiratory failure with hypoxia (a sudden, dangerous worsening of chronic low oxygen levels with a pre-existing lung disease); - An order for oxygen 2 LPM continuously, dated 05/06/25; - An order to change the oxygen canister and tubing every Sunday, dated 05/06/25. Observation of the resident on 03/24/26 at 12:06 P.M., showed: - The resident lay in bed with oxygen on at 3.5 LPM via an undated NC in his/her left nostril only per the oxygen concentrator. Observation on 03/27/26 at 9:30 P.M., and 12:00 P.M., showed: - The resident lay in bed with oxygen on at 3 LPM via an undated NC per the oxygen concentrator. During an interview on 03/24/26 at 12:06 P.M., the resident said the staff changed the oxygen tubing when they realize it had not been changed in a while. During an interview on 03/27/26 at 10:18 A.M., Licensed Practical Nurse (LPN) G said oxygen tubing should be changed weekly, dated when changed, placed in a bag when not in use, and the resident should have an order for oxygen that matched the setting. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/26 at 1:42 P.M., the Director of Nursing (DON) said the oxygen setting should match the physician's order and tubing should be labeled with the date it was changed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to establish a system of records for the receipt and disposition of all controlled medications in sufficient detail to enable an accurate reconciliation of the controlled medications and to ensure nursing staff counted and signed the narcotic count sheet at the beginning and at the end of each shift for four out of four sampled medication carts. The facility census was 126.The facility did not provide a policy regarding the receipt and disposition of controlled medications or reconciliation of controlled medications. 1. Review of the 100 Hall Certified Medication Technician (CMT) Cart Change of Shift Narcotic Count sheet, dated 03/01/26 - 03/26/26, showed:- No signature and/or initials by the nurse or CMT for 63 out of 151 opportunities. During an interview on 03/26/26 at 12:02 P.M., CMT F said all narcotics should be counted at the beginning and end of each shift and the count sheet should be signed verifying the count was completed and accurate. 2. Review of the 100 Hall Nurse Cart Change of Shift Narcotic Count Sheet, dated 03/01/26 - 03/27/26, showed:- No signature/and or initials by the nurse for 86 out of 157 opportunities. During an interview on 03/27/26 at 11:50 A.M., Licensed Practical Nurse (LPN) G said narcotics should be counted by the oncoming and off going nurse and the narcotic sheet should be signed when counted. 3. Review of the 400 Hall CMT Cart Narcotic Package Count Shift Reconciliation sheet, dated 03/12/26 - 03/26/26, showed:- No designated signature space for oncoming staff to sign;- No signature and/or initials by the nurse or CMT for the oncoming shift for 43 out of 43 opportunities;- No signature and/or initials by the nurse or CMT for the off going shift for four out of 43 opportunities. During an interview on 03/26/26 at 2:00 P.M., CMT B said the count sheet should be signed when coming on shift and going off shift after counting the narcotics. 4. Review of the 400 Hall Nurse Cart Narcotic Package Count Shift Reconciliation sheet, dated 03/12/26 - 03/26/26, showed:- No designated signature space for oncoming staff to sign;- No signatures/and or initials by the nurse for the oncoming shift for 44 out of 44 opportunities;- No signature/and or initials by the nurse for the off going shift for 14 out of 44 opportunities. During an interview on 03/26/26 at 2:05 P.M., LPN H said he/she knew there were some dates not signed on the sheet, but staff should sign and count the narcotics at the start of their shift and again at the end of their shift. During an interview on 03/27/26 at 1:45 P.M., the Director of Nursing (DON) said she would expect staff to count narcotics at the beginning and end of every shift and sign the count sheet.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications and biologicals were stored in accordance with currently accepted practices when refrigerator temperatures were not completed for the Certified Medication Technician (CMT) and Nurse refrigerators, located on the 100 Hall. The facility also failed to ensure one resident (Resident #24) out of 25 sampled residents had a physician's order to keep an inhaler (hand-held portable device that delivers medication to the lungs) at the bedside. This had the potential to affect all residents. The facility census was 126. Review of the facility's policy titled, Storage of Medications, revised 07/22/24, showed: - Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received; - Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications must be stored separately from food and must be labeled accordingly; - Did not address checking and the appropriate refrigerator temperatures; - Did not address a resident keeping a medication at the bedside. Review of the package insert for Tubersol (a solution used in a skin test to help diagnose tuberculosis (TB - a serious illness that mainly affects the lungs), on fda.gov, undated, showed: - Store at 35 - 46 degrees Fahrenheit (ˆF); - Do not freeze, discard product if exposed to freezing; - A vial which has been entered and in use for 30 days should be discarded. Review of the package insert for Lantus (long acting insulin) insulin pens, on lantus.com, dated v2.0-08/2022, showed: - Before opening, store Lantus in the refrigerator (36 - 46 ˆF); - Lantus can be refrigerated until the expiration date, once the expiration date has passed, Lantus should be thrown away; - Do not allow Lantus to freeze. Review of the package insert for Novolog (a rapid acting insulin) insulin pens, on novolog.com, dated September 2025, showed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Store unused Novolog pens and vials in refrigerator at 36 - 46 ˆF until expiration; - Storage after use, keep at room temperature (below 86 degrees F) or refrigerate for up to 28 days; - Keep away from direct heat and light; - Dispose of after 28 days. Review of the package insert for Trulicity (an injectable medication used to decrease insulin secretion, on trulicity.lilly.com, dated 12/2025, showed: - Store the pen in the refrigerator, but do not freeze the pen. Review of the package insert for influenza vaccine, on cdc.gov, last reviewed 09/16/16, showed: - Vaccines should be stored at recommended temperatures; - In general, influenza vaccines should be refrigerated between 36 - 46 ˆF and should not be frozen, vaccines that have been frozen should be discarded; - Vaccines should not be used after the expiration date on the label. Review of the package insert for cyanocobalamin (vitamin B 12) vials, undated, on dailymed.nlm.nih.gov, showed: - Store at 68 - 77ˆF. Review of the package insert for acetaminophen suppositories (a pain/fever reliever in a small solid that is inserted into the body via the rectum that melts or dissolves at body temperature), on medlineplus.gov, revised 10/15/25, showed: - Keep this medication in the container it came in, tightly closed; - Store it at room temperature and away from excess heat and moisture. Review of the package insert for Bisacodyl suppositories (fast acting, stimulant laxative that is inserted rectally to relieve constipation), on medlineplus.gov, revised 11/15/16, showed: - Keep this medication in the container it came in, tightly closed; - Store at room temperature and away from excess heat and moisture. 1. Review of the 100 Hall med room/Nurse Refrigerator Temperature Log for 03/1/26 - 03/26/26 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed: - No temperatures recorded for 03/01, 03/04, 03/07, 03/13 - 03/15, 03/18, 03/19, and 03/21 - 03/25, with 13 missed out of 31 opportunities; - A temperature of 34ˆF on 03/02, 03/03, 03/05, 03/08 - 03/10, 03/12, 03/16, 03/17, 03/20, and 03/26; - A temperature of 32ˆF on 03/06/26. Observation on 03/26/26 at 11:50 A.M., of the 100 Hall med room/Nurse refrigerator showed: - A thermometer reading of 34ˆF; - Four unopened vials of Tubersol; - One opened vial of Tubersol, dated 03/24/26; - 33 unopened Lantus and Novolog insulin pens; - One unopened Trulicity pen; - 11 unopened, single use influenza vaccines; - Two unopened vials of cyanocobalamin; - 63 unopened acetaminophen suppositories; - 26 unopened Bisacodyl suppositories. 2. Review of the 100-hall med room/CMT refrigerator temperature log for 03/01/26 - 03/26/26 showed: - No temperatures recorded for 03/01, 03/04, 03/11, 03/13-03/15, 03/18, 03/21, and 03/22, with nine missed out of 31 opportunities; - A temperature of 34ˆF on 03/02, 03/03, 03/05, 03/07 - 03/10, 03/12, 03/16, 03/17, 03/19, and 03/20. Observation on 03/26/26 at 11:58 A.M., of the 100 Hall med room/CMT refrigerator showed: - A thermometer reading of 34ˆF. During an interview on 03/26/26 at 12:00 P.M., CMT F said the day shift CMT was responsible for checking the refrigerator temperatures and the logs should be updated daily. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/26 at 1:45 P.M., the Director of Nursing (DON) said she would expect refrigerator temperatures to be recorded daily and within the appropriate range. 2. Review of Resident #24's medical record showed: - An admission date of 10/30/25; - An order for albuterol sulfate (a bronchodilator medication used to open the airways) hydrofluoroalkane (HFA – a propellant in an inhaler) 90 microgram (mcg)/actuation 2 HFA aerosol inhaler inhalations four times a day as needed for shortness of breath nebulization, dated 03/10/26; - No order for medications to be kept at bedside; - No documentation of an assessment for the medication to be self-administered safely; - Did not address the self-administration of the medication on the care plan. Observations of the resident's room showed: - On 03/25/26 at 10:33 A.M., 03/06/26 at 11:47 A.M., and 03/27/26 at 9:00 A.M., the albuterol sulfate HFA 90 mcg aerosol inhaler on the resident's bedside table. During an interview on 03/27/26 at 9:00 A.M., the resident said he/she used the albuterol inhaler about once a day if needed. He/She used it when having difficulty breathing. During an interview on 03/27/26 at 11:05 A.M., CMT B said if residents had medications at bedside, the residents were supposed to tell staff when the medications were used so that staff could chart it in the resident's medical record. He/She said Resident #24 had not told him/her about using the inhaler at bedside and did not know if he/she really ever used the inhaler. There should be an order by the physician to say the resident could use medication at the bedside. During an interview on 03/27/26 at 12:00 P.M., Licensed Practical Nurse (LPN) C said he/she did not think there was a documented formal assessment to be completed for residents with medications at the bedside. He/She would expect the resident to tell staff when taking medications stored at the bedside. There should be an order in the resident's medical record by the physician to the say resident could use medication at the bedside. During an interview on 03/27/26 at 1:50 P.M., the DON said she would expect there to be a physician's order to use a medication at the bedside. She did not think there was a formal assessment documented anywhere but the resident should be assessed for safety and should tell staff when a medication was self-administered at the bedside.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow infection control precautions by not changing gloves or washing hands during resident care for four residents (Residents #7, #11, #103, and #134) out of six sampled residents, by not following enhanced barrier precautions (EBP - precautions for use during high-contact resident care activities for residents infected with a multidrug-resistant organism (MDRO - microorganisms that are resistant to one or more classes of antimicrobial agents) or any resident who has a chronic wound and/or indwelling medical device) for five residents (Residents #7, #41, #103, #104, and #134) out of five sampled residents, and during medication administration for three residents (Residents #38, #104 and #141) out of seven sampled residents. The facility census was 126.Review of the facility's policy titled, Policy and Procedure - Enhanced Barrier Precautions, dated 04/01/24, showed: - Whenever a resident has an infection regardless of their MDRO status, the community will utilize EBP for any time that physical contact is needed in caring for the resident. The EBP will be utilized by the staff for any residents with chronic wounds or indwelling medical devices during any high contact with that resident; - The gowns and gloves will be outside the resident room for the staff to don before entering the room and two containers will be in the room, 1) for soiled linens and clothing and 2) for the soiled gloves and gowns to be disposed of after use by the staff; - The staff will always adhere to universal precautions and perform handwashing before exiting the room; - In-services for EBP for the staff will be conducted every six months; - Did not address high contact resident care activities. The facility did not provide a hand hygiene policy. 1. Observation of Resident #7's wound care on 03/25/26 at 10:50 A.M., showed: - No EBP signage outside of the resident's room; - Registered Nurse (RN) J and Certified Nurse Assistant (CNA) K performed hand hygiene, put on gloves, and did not put on a gown; - RN J removed the soiled dressing from the resident's left shin and ankle and placed it in the trash can beside the bed; - RN J removed the soiled packing strip from the shin wound, did not perform hand hygiene, did not change gloves, sprayed the shin wound with wound cleaner, wiped with gauze, did not perform hand hygiene, and did not change gloves; - RN J sprayed the ankle wound with wound cleaner, wiped with gauze, did not change gloves, and did not perform hand hygiene; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- RN J packed the left shin wound with plain packing strip, covered with silver alginate, covered with an ABD pad, wrapped with Kerlix, and secured with clear tape; - RN J did not perform hand hygiene, changed gloves, covered the left ankle wound with silver alginate, applied barrier cream around the wound, wrapped with Kerlix, and secured with clear tape; - RN J and CNA K removed gloves, performed hand hygiene, and exited the room. 2. Observation on 03/25/26 at 11:16 A.M., of Resident #134's wound care showed: - No EBP signage outside of the resident's room; - RN J and CNA K performed hand hygiene, put on gloves, and did not put on a gown; - RN J removed the soiled dressings; - RN J did not perform hand hygiene and changed gloves; - RN J sprayed wound cleaner on the right and left buttock wounds, wiped the left buttock with gauze, did not perform hand hygiene, did not change gloves, wiped the right buttock with gauze, did not perform hand hygiene, and changed gloves; - RN J covered the left and right buttock wounds with silicone border gauzes; - RN J removed gloves, did not perform hand hygiene, and covered resident with a blanket; - CNA K and RN J performed hand hygiene before leaving the room. During an interview on 03/26/26 at 10:15 A.M., RN J said he/she had never heard of EBP. Gowns, gloves, and masks should be worn during wound care, and that hand hygiene should be performed before, after, and when going from dirty to clean tasks during wound care. 3. Observation on 03/26/26 at 8:25 A.M., of Resident #141's medication administration showed: - Certified Medication Technologist (CMT) F did not perform hand hygiene; - CMT F obtained an acetaminophen (a medication that reduces pain and fever) 650 milligram (mg) tablet from the medication cart and poured it directly from the stock medication container into his/her bare hand and placed the medication into a pill cup; - CMT F placed 10 additional medications into the same pill cup; - CMT F administered the medications to the resident. 4. Observation on 03/26/26 at 8:35 A.M., of Resident #38's medication administration showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CMT F did not perform hand hygiene, - CMT F obtained a loratadine (a medication that treats allergies) 10 mg tablet from the medication cart and poured it directly from the stock medication container into his/her bare hand and placed the medication into a pill cup; - CMT F placed five additional medications into the same pill cup; - CMT F administered the medications to the resident; - CMT F obtained a bottle of cyclosporine (medication that treats chronic dry eyes) 0.05% eye drops from the medication cart; - CMT F did not perform hand hygiene, put on gloves, administered the eye drops to the resident's right and left eyes; - CMT F obtained a facial tissue and blotted the left and the right eye with the same tissue. During an interview on 03/26/26 at 10:15 A.M., CMT F said he/she should not touch medications with his/her bare hands and should sanitize or wash his/her hands prior to and after administering medications. He/She should not use the same tissue to blot both eyes. 5. Observation on 03/26/26 at 12:30 P.M., of Resident #104's intravenous (IV – administered into a vein) antibiotic medication administration showed: - No EBP signage outside of the resident's door; - Licensed Practical Nurse (LPN) H performed hand hygiene, put on a mask and gloves, and did not put on a gown; - LPN H entered the resident's room, performed hand hygiene and put on a mask and gloves; - LPN H administered the ceftriaxone (an antibiotic medication) IV medication to the resident. During an interview on 03/26/26 at 12:40 P.M., LPN H said EBP should include a gown and gloves, and EBP should be worn during hands on care, such as for dressing, urinary catheter care, and IVs. 6. Observation on 03/27/26 at 9:37 A.M., of Resident #103's catheter care showed: - No EPB signage; - CNA I entered room, performed hand hygiene, put on gloves, and did not put on a gown; - CNA I cleaned the resident's front peri area, didn't perform hand hygiene, and changed gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA I cleaned the urinary catheter from the insertion site and away, didn't perform hand hygiene, and changed gloves; - CNA I cleaned the resident's buttocks, removed the soiled brief, did not perform hand hygiene, did not change gloves, placed a clean brief on the resident, adjusted the incontinent pad under the resident, pulled the resident up in the bed with the incontinent pad, placed the blanket over the resident, removed gloves, performed hand hygiene, and exited the room. During an interview on 03/27/26 at 11:56 A.M., CNA I said he/she did not know anything about EBP. He/She wore gloves and a gown when a resident was on contact or airborne isolation. Hand hygiene should be performed before and after perineal care, before helping a resident eat, and sometimes when changing gloves. Gloves should be changed when they were soiled or going from a dirty to clean task. 7. Observation on 03/27/26 at 9:45 A.M., of Resident #11's incontinent care showed: - CNA A cleaned the resident's right front peri area with a wet wash cloth, didn't perform hand hygiene, changed gloves, cleaned the left front peri area, did not perform hand hygiene, changed gloves, cleaned the back peri area and the buttocks with a wet wash cloth, did not perform hand hygiene, changed gloves, and dried the resident with a dry wash cloth. 8. Observation on 03/27/26 at 10:58 A.M., of Resident #41's incontinent care showed: - No EBP signage outside the resident's room; - CNA A and CNA E entered the room, performed hand hygiene, put on gloves, and did not put on a gown; - CNA A and CNA E performed the resident's incontinent care and the resident had a urinary catheter (a tube inserted into the bladder to drain urine) and a wound. During an interview at 03/27/26 at 10:50 A.M., CNA A said he/she did not know what residents were supposed to be on EBP or what it really was for. He/She got report from other staff about what residents had precautions. He/She changed gloves and washed hands when going from clean to dirty and dirty to clean tasks. 9. Observation on 03/27/26 at 11:24 A.M., of Resident #41's wound care showed: - No EBP signage outside the resident's room; - LPN G entered the room, performed hand hygiene, put on gloves, and did not put on a gown; - LPN G performed the resident's wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. Observation on 03/27/26 at 11:37 A.M., of Resident #41's transfer showed: - No EBP signage outside of the resident's room - CNA A and CNA E entered the room, performed hand hygiene, put on gloves, and did not put on a gown; - CNA A and CNA E transferred the resident. During an interview on 03/27/26 at 11:45 A.M., LPN G said gloves and gowns should be worn for high contact care of residents with urinary catheters and/or chronic wounds. During an interview on 03/27/26 at 12:00 P.M., LPN C said he/she did not know what EBP was or who qualified for being on it. He/She got information about who was on precautions from other staff. During an interview on 03/27/26 at 11:10 A.M., the Director of Nursing (DON)/Infection Preventionist (IP) said she would expect staff to perform hand hygiene before, after, and when going from dirty to clean tasks during wound care or resident care tasks. Only residents who had a weird wound, who were infectious, or had an organism listed on the list provided by the Centers of Disease Control and Prevention (CDC) should be on EBP. Residents should only be on EBP for the chronic phase of the infection, so they would be on EBP for the rest of their lives. Residents who were on EBP should have a sign on their door and an isolation cart outside of the room. When performing high contact care for a resident with a chronic wound or indwelling device who are on EBP, she would expect staff to wear a gown and gloves. During an interview on 03/27/26 at 1:45 P.M., the DON/IP said staff should not touch medications with their bare hands and should sanitize or wash their hands prior to and after administering medications. EBP should be worn when caring for and administering medications through an IV. During an interview on 03/30/26 at 10:00 A.M., the Administrator said he would expect staff to follow EBP precautions for residents who qualify and would expect staff to change gloves and wash hands before, after, and when going from dirty to clean tasks during resident care. Staff should not touch medication with their bare hands and should perform hand hygiene prior to and after administering medications.