STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lenoir Health and Rehabilitation Center	322 Nuway Circle Lenoir, NC 28645

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and Nurse Practitioner, Psychiatric Nurse Practitioner, and staff interviews, the facility failed to obtain consent and inform the resident in advance of the risks and benefits of psychotropic medications prior to the initiation of the antianxiety medication clonazepam and the antidepressant medication venlafaxine for 1 of 5 residents reviewed for unnecessary medications (Resident #45).The findings included:Resident # 45 was admitted [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), bipolar disorder, and depressive disorder. A Psychiatric Nurse Practitioner progress note dated 07/28/2025 indicated Resident #45 had experienced panic attacks 3 to 4 times weekly with symptoms that felt like he was having a heart attack. The plan indicated to start clonazepam twice a day. Resident #45's physician orders revealed an order dated 07/28/2025 for clonazepam 0.5 milligrams (mg) by mouth twice a day for anxiety. Resident #45's quarterly Minimum Data Set (MDS) dated [DATE] revealed intact cognition and indicated Resident #45 received antianxiety and antidepressant medications on a routine basis during the 7-day look back period. Resident #45's physician orders revealed an order dated 08/12/2025 for the venlafaxine 75 mg by mouth daily for depression. A review of Resident # 45's medical record revealed no information whether Resident #45 was informed in advance of the risks and benefits of initiating clonazepam or venlafaxine and consented to the treatment. The Medication Administration Record (MAR) from 07/28/2025 to 11/18/2025 indicated Resident #45 was administered clonazepam and venlafaxine as ordered by the physician. An interview with Resident #45 on 11/17/2025 at 10:05 AM revealed Resident #45 was in good spirits, and he stated his anxiety and his depression were well controlled. An interview with the Nurse Practitioner on 11/19/2025 at 10:30 AM revealed she deferred Resident #45's psychotropic medication management to the Psychiatric Nurse Practitioner (NP) and she did not obtain consents for these medications. An interview with the Director of Nursing (DON) on 11/19/2025 at 2:00 PM revealed that the facility had not consistently been obtaining consents for psychotropic medications. The DON stated she thought that sometimes the psychiatric Nurse Practitioner obtained consents prior to starting the psychotropic medication. An interview with the Psychiatric Nurse Practitioner on 11/20/2025 at 9:00 AM indicated the nursing staff were supposed to notify the resident or the responsible party to discuss the treatment and the possible side effects when a psychotropic medication was initiated or the dosage had been increased. The Psychiatric Nurse Practitioner indicated that her discussion with Resident #45 consisted of asking the resident about mood fluctuations, anxiety episodes, and his degree of depression. An interview with Administrator on 11/20/2025 at 9:42 AM revealed that she was aware there was opportunity for improvement related to the use of psychotropics and informed consents. She stated that she expected informed consents including a discussion of the risks and benefits would be obtained prior to starting or changing a psychotropic medication.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, staff, Nurse Practitioner (NP), and Medical Director interviews, the facility failed to notify the physician immediately of abdominal bruising on a resident receiving Plavix and aspirin (antiplatelet medications) for 1 of 5 residents reviewed for unnecessary medications (Resident #23). The facility also failed to notify the physician before turning off a continuous enteral feeding (tube feeding) when a resident's blood sugar was elevated for 1 of 3 residents reviewed for tube feeding (Resident #63).The findings included: Resident #23 was admitted to the facility on [DATE] with diagnoses which included type-2 diabetes mellitus with chronic kidney disease, peripheral vascular disease (a condition of decreased blood flow in the lower extremities), and atherosclerotic heart disease (a heart condition caused by plaque buildup in the walls of arteries blocking blood flow to the heart). A review of Resident #23's physician orders revealed the following: Plavix 75 milligrams by mouth daily for peripheral vascular disease Aspirin 81 milligrams by mouth daily for atherosclerotic heart disease Insulin Glargine (long-acting insulin) Pen-Injector (100 Unit/Milliliter) inject 15 unit subcutaneously (under skin) every 12 hours for type-2 diabetes NovoLOG (Regular insulin) Solution Pen-Injector (100 Unit/Milliliter) inject subcutaneously before meals and at bedtime per sliding scale: if blood sugar 150-200 give 2 units; 201-250 give 4 units; 251-300 give 6 units; 301-350 give 8 units; 351-450 give 10 units; above 450 notify provider A progress note written by Nurse #1 dated 11/15/25 at 7:30 PM revealed the following: A large bruise was noted on the left lower quadrant of abdomen. Bruise purple/blue in appearance. An interview with Nurse #1 was conducted on 11/17/25 at 10:33 AM. Nurse #1 revealed that on the morning of 11/15/25 at 6:00 AM, a skin assessment was performed on Resident #23 which revealed no injury. Nurse #1 further revealed when she arrived for her next shift on the evening of 11/15/25 at 7:30 PM, Resident #23 reported pain to abdominal area. Nurse #1 visualized the abdominal area and noted a purple bruise to Resident #23's left lower quadrant of abdomen. Nurse #1 stated she did not notify the provider. An interview with Unit Manager #1 was conducted on 11/16/25 at 1:42 PM. Unit Manager #1 revealed that she had come in at 3:00 PM on 11/15/25. Unit Manager #1 stated she assessed Resident #23 and noted a large bruise to the left lower quadrant of Resident #23's abdomen. Unit Manager #1 indicated that she did not notify the provider at that time. An interview of Resident #23 was performed on 11/16/25 at 11:16 AM. Resident #23 revealed a large bruise to left abdomen during the interview. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview with Unit Manager #2 was conducted on 11/17/25 at 6:16 PM. Unit Manager #2 reported on the night of 11/16/25, Resident #23 stopped to show her the bruising on her abdomen. Unit Manager #2 stated that she did not report it to the provider. An interview with the NP was conducted on 11/18/25 at 3:01 PM. The NP stated that she was not notified of the bruised area to Resident #23 until the AM of 11/17/25. The NP stated that when she became aware of the bruising, Resident #23 was seen by her in clinic. The NP stated the Plavix and aspirin are antiplatelet medication that Resident #23 received daily and could have contributed to bruising and Resident #23 received insulin injections which are commonly administered in the abdominal area. The NP indicated the provider should have been notified when the bruising was first assessed. 2. Resident #63 was admitted to the facility on [DATE]. Resident #63 had diagnoses that included diabetes mellitus (DM) type 2, encounter for attention to gastrostomy. Resident #63 had a physician's order dated 6/29/2024 for enteral feeding (method of delivering nutrition directly into the gastrointestinal tract through a feeding tube) for Nutren 2.0 (feeding formula) at 46 milliliters (ml)/hour (hr) administered continuously from 9:00 PM to 9:00 AM daily. Resident #63 had a physician's order dated 6/29/2024 for blood sugar checks four times daily before meals and at bedtime for DM. An order dated 2/26/2025 for Lantus inject 20 units subcutaneously at bedtime for diabetes mellitus if CBG less than 65 only give 10 units. Notify provider if CBG is less than 60 or greater than 450. A progress note dated 8/1/2025 written by Nurse #3 revealed Resident #63's blood glucose was 335 milligram/deciliter mg/dl, tube feeding stopped early to help blood glucose stabilize. During a telephone interview on 11/17/2025 at 4:56 PM Nurse #3 revealed she worked at the facility on the 7:00 PM to 7:00 AM shift and was familiar with Resident #63. Nurse #3 confirmed she had turned off Resident #63's tube feeding early due to high blood sugar on the morning of 8/1/2025. Nurse #3 stated she didn't think she needed to get a doctor's order to turn off a tube feeding early and stated she thought it was nursing judgement. Nurse #3 stated she thought it was better to turn the tube feeding off early instead of calling a provider to try and get coverage orders when it would take a couple hours to hear back from the provider. Nurse #3 confirmed she did not notify the provider when she turned the tube feeding off early. An order for enteral feeding dated 10/4/2025 for Nutren 2.0 administer 65ml/hr continuously at 9:00 PM and off at 9:00 AM. During a telephone interview on 11/19/2025 at 8:20 AM Nurse #1 stated she worked at the facility since September 2025 and currently worked the 7:00 PM to 7:00 AM shift at the facility and was familiar with Resident #63. Nurse #1 stated one night in October 2025, she did not recall the specific date, she was worried about Resident #63 having a high blood sugar over 400, and no orders for sliding scale insulin coverage at that time. Nurse #1 stated she asked another nurse, she could not remember which one, what to do and the nurse told her to turn off the tube feeding. Nurse #1 stated she thought they had been turning off the tube feeding early due to high blood sugars, so Nurse #1 turned off Resident #63's tube feeding and did not notify the provider. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 11/18/2025 at 7:05 AM Unit Manager #4 stated sometime around mid-October Nurse #1 reported to Unit Manager #4 that Resident #63's tube feeding had been held due to high blood sugar, that other nurses had done it since Resident #63 had no sliding scale insulin coverage for elevated blood sugars. Unit Manager #4 stated she told Nurse #1 that a tube feeding was not supposed to be turned off for elevated blood sugars, and a provider should have been notified. Unit Manager #4 stated she reported the information the NP #2 who gave new sliding scale insulin coverage orders, and to the Director of Nursing (DON). Review of a progress note from the NP #2 dated 10/13/2025 revealed in part, NP #2 had seen Resident #63 on 10/13/2025 regarding weight loss, with an additional note that revealed NP #2 had a telephone encounter 10/15/2025 and spoke with bedside nurse who stated that Resident #63 received before meals and a bedtime blood glucose checks without any sliding scale insulin coverage in place. Per nurse- tube feeding was stopped by night shift nurse due to blood sugar of 446. Per nursing reports tube feeding gets turned off frequently due to elevated blood sugars. Reviewed blood sugars and added sliding scale insulin coverage and would continue to monitor and adjust plan of care as needed. During a telephone interview on 11/17/2025 at 4:29 PM the Nurse Practitioner (NP) #2 stated she was notified by the facility that Resident #63's had weight loss in early October 2025 and Resident #63's tube feeding rate was reviewed by the RD and the tube feeding rate was increased. The NP #2 stated near the middle of October, Unit Manager #4 reported that when Resident #63 had elevated blood sugars the nurses had turned off Resident #63's tube feeding instead of calling the provider to get orders for insulin. NP #2 stated she expected nurses to administer tube feedings as ordered and should contact a provider to get an order for a tube feeding to be turned off early. During an interview on 11/19/2025 at 4:50 PM the Medical Director stated he expected tube feedings to be administered as ordered and to be contacted by the nurse to receive orders to turn a tube feeding off early, and for a provider to be notified for blood sugars over 400, if a resident did not have an order for coverage. During an interview on 11/18/2025 at 8:45 AM the DON stated a physician ordered tube feeding should not be turned off early unless the nurse contacted the provider and received orders to turn the feeding off early. During an interview on 11/20/2025 at 7:10 AM the Administrator stated she expected nurses to administer tube feedings as ordered, and to contact a provider for an order to turn a tube feeding off early.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident interviews, the facility failed to develop abuse policies and procedures that directed staff on how to immediately protect residents after an abuse allegation. The facility also failed to implement their abuse policy in the areas of reporting and training. An allegation of staff to resident physical abuse occurred on 11/15/25. The facility failed to immediately remove the alleged perpetrators from the facility, immediately notify the Administrator of the abuse allegation, and train staff on immediately reporting abuse allegations to administration. This deficient practice occurred for 1 of 3 residents reviewed for abuse (Resident #23). Findings included: Review of the facility's abuse policy titled Patient Protection dated 10/17/23 revealed all employees are responsible for immediately (no later than 2 hours after the allegation is made if the incident involves abuse or bodily injury, no later than 24 hours if the incident does not involve abuse of bodily injury) reporting to the Administrator, or in their absence, the Director of Nursing, or their immediate supervisor any and all suspected or witnessed incidents of patient abuse, neglect, theft, exploitation, and/or mistreatment of a patient as well as any reasonable suspicion of a crime against a patient. Any and all suspected or witnessed incidents of patient abuse, neglect brought to the attention of Administration will result in internal investigation, appropriate and timely reporting to the State Agency and other legally designated agencies, as well as staff corrective action, suspension, and/or termination as necessary. The abuse policy did not direct staff to immediately protect all residents after an abuse allegation by removing alleged perpetrators from access to residents. Review of the facility's abuse policy titled Prevention/Screening/Training dated 02/05/23 revealed all employees receive training in orientation and are routinely in-serviced regarding the definitions of abuse, neglect.and their responsibility for understanding and preserving patient rights, protecting patients from abuse and neglect, and their responsibility to immediately report any cases of suspected or witnessed abuse or neglect. Resident #23 was admitted to the facility on [DATE].A review of Resident #23's quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #23 was cognitively intact. A telephone interview with Nursing Assistant (NA) #2 was conducted on 11/16/25 at 3:48 PM. NA #2 reported that she was assigned to Resident #23 the night of 11/15/25. At around 5:40 AM, NA #2 entered Resident #23's room for rounds where NA #1 was present providing care to Resident #23's roommate. Resident #23 refused incontinence care three times and NA #2 stated that there was a planned refusal form for Resident #23 to sign if she refused care due to frequent refusals. When NA #2 got the form, Resident #23 became agitated and began cursing. NA #1 then asked Resident #23 if she wanted to be changed to which Resident #23 agreed for NA #2 to complete incontinence care at that time. NA #2 had Resident #23 roll to her right side facing the window, then tapped her to roll over to her back. NA #2 stated that when Resident #23 rolled back onto her back, she began yelling you are in my organs. NA #2 stated that she was not touching Resident #23 at the time she began yelling. NA #2 stated that there was no bruising on Resident #23's abdomen at that time. NA #2 reported the incident to Unit Manager #2. NA #2 indicated that Resident #23 was her last resident for rounds and she left at 7:00 AM. NA #2 reported that her assignment was not changed for the brief period left in her shift. NA #2 indicated she had been off since and had not returned due to previously scheduled time off. An interview with NA #1 was conducted on 11/16/25 at 3:19 PM. NA #1 revealed that she had arrived at work the 3:00 PM to 11:00 PM shift at the time of the interview. NA #1 stated that she was in Resident #23's room providing incontinence care for Resident #23's roommate on 11/15/25 at 5:40 AM. NA #2 entered the room to provide incontinence care for Resident #23. NA #1 stated she was not assigned to Resident #23 because she would not work with Resident #23. NA #1 stated that she would have another NA provide care to Resident #23. NA #2 worked with Resident #23 on the 11/15/25 7:00 PM to 7:00 AM shift. NA #1 observed NA #2 offer incontinence care to Resident #23 who refused 3 times. When NA #2 requested Resident #23 sign the planned refusal form, Resident #23 became upset and began cursing. NA #1 reported that she stated to Resident #23, are you going to let her change you? At that time, Resident #23 agreed to incontinence care by NA #2. NA #1 did not assist with care but observed Resident #23 had rolled to her right side facing the window when NA #2 tapped gently on Resident #23's left hip to get her to turn over (Resident #23 is hard of hearing so this is how they indicate to her to turn). NA #1 observed Resident #23 roll over onto her back and NA #2 was at the bedside not touching Resident #23 when Resident #23 began yelling you're hurting my organs. NA #1 reported that she told NA #2 to stop and told her to go get Nurse #1. NA #1 indicated that she left the room after completing care for

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and staff interviews, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days following hospice election for 1 of 1 resident reviewed for hospice (Resident #73).The findings included:Resident #73 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, unspecified dementia, and senile degeneration of the brain.A medical record review revealed Resident #73 was admitted to hospice on 09/19/25 with a primary hospice admission diagnoses of senile degeneration of the brain.A review of Resident #73's MDS assessments revealed a significant change in status MDS assessment was completed on 10/16/25 after the resident was admitted to hospice services. The MDS was coded for hospice care. An interview with the facility MDS Nurse was conducted on 11/20/25 at 10:04 AM. The MDS Nurse stated if a resident was admitted to hospice services, a significant change in status MDS assessment should be completed within 14 days. The MDS Nurse reported that no significant change in status MDS assessment was completed for Resident #73 within the required 14-day period. The MDS Nurse stated that several residents had been admitted to hospice services around the same time and she overlooked the significant change in status MDS for Resident #73. An interview was conducted with the Director of Nursing (DON) on 11/20/25 at 10:34 AM. The DON stated residents admitted to hospice services was considered a significant change and a significant change in status MDS assessment should have been completed within 14 days of hospice admission date.An interview with the Administrator was conducted on 11/20/25 at 11:19 AM. The Administrator stated that a significant change in status MDS should have been completed within 14 days after Resident #73 was admitted to hospice.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and Medical Director, Nurse Practitioner (NP), staff, and resident interviews, the facility failed to complete and document thorough assessments of abdominal bruising on a resident that received Plavix (antiplatelet medication) and aspirin daily. The facility also failed to follow physician orders for daily scheduled treatment of surgical wounds. These practices occurred for 2 of 4 residents reviewed for providing care to maintain wellbeing (Resident #23 and Resident #105). Findings included: Resident #23 was admitted to the facility on [DATE] with diagnoses which included type-2 diabetes mellitus with chronic kidney disease, peripheral vascular disease (a condition of decreased blood flow in the lower extremities), and atherosclerotic heart disease (a heart condition caused by plaque buildup in the walls of arteries blocking blood flow to the heart). A review of Resident #23's physician orders revealed the following: Plavix 75 milligrams by mouth daily for peripheral vascular disease Aspirin 81 milligrams by mouth daily for atherosclerotic heart disease Insulin Glargine (long-acting insulin) Pen-Injector (100 Unit/Milliliter) inject 15 unit subcutaneously (under skin) every 12 hours for type-2 diabetes NovoLOG (Regular insulin) Solution Pen-Injector (100 Unit/Milliliter) inject subcutaneously before meals and at bedtime per sliding scale. A progress note dated 11/15/25 at 7:30 PM written by Nurse #1 revealed the following: A large bruise was noted on the left lower quadrant of abdomen. Bruise purple/blue in appearance. An interview with Nurse #1 was conducted on 11/17/25 at 10:33 AM. Nurse #1 revealed that on the morning of 11/15/25 at 6:00 AM, a skin assessment was performed on Resident #23 which revealed no bruising. Nurse #1 stated she did not document that skin assessment in the electronic medical record. Nurse #1 further revealed when she arrived for her next shift on the evening of 11/15/25 at 7:30 PM, Resident #23 reported pain to abdominal area. Nurse #1 visualized the abdominal area and noted a large purple bruise to Resident #23's left lower quadrant of abdomen. Nurse #1 stated she completed a progress note but did not complete measurements or documentation of the skin assessment in the electronic medical record. An interview with Unit Manager #1 was conducted on 11/16/25 at 1:42 PM. Unit Manager #1 revealed that she had come in at 3:00 PM on 11/15/25. Unit Manager #1 stated she assessed Resident #23 and noted a large bruise to the left lower quadrant of Resident #23's left lower abdomen. Unit Manager #1 indicated that she did not complete measurements or documentation of the skin assessment in the electronic medical record. Unit Manager #1 did not complete a progress note. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview with Unit Manager #2 was conducted on 11/17/25 at 6:16 PM. Unit Manager #2 reported on the night of 11/16/25, Resident #23 stopped to show her the bruising on her abdomen. Unit Manager #2 stated that she did not document completion of the skin assessment in the electronic medical record or complete a progress note. An observation and interview with Resident #23 was performed on 11/16/25 at 11:16 AM. Resident #23 revealed a large area of diffuse (no defined shape) bluish purple bruising to left lower abdomen during the interview. Resident #23 stated that the area was painful and rated her pain level at an 8 out of 10 at that time (zero (0) meaning no pain and 10 meaning the worst pain). An interview with the NP was conducted on 11/18/25 at 3:01 PM. The NP stated that she was notified of the bruised area to Resident #23 on the morning of 11/17/25 and saw Resident #23 in clinic. The NP indicated that she assessed a hematoma (a collection of blood under the skin) to Resident #23's left lower quadrant of abdomen. The NP reported that area was tender per Resident #23 and appeared slightly swollen. The NP stated that the Plavix and aspirin that Resident #23 received daily placed her at risk for bleeding and could have contributed to the bruising. The NP stated Resident #23 also received insulin injections which are commonly administered in the abdominal area and may cause bruising to injection site areas. The NP indicated she ordered an abdominal x-ray and blood work to be performed STAT (immediately) on 11/17/25. The NP reported that labs were received and were within normal limits with no concerns about active bleeding. The abdominal ultrasound was still pending due to the ultrasound company's schedule. A review of laboratory results performed 11/17/25 at 3:00 PM revealed the following: aPTT (activated partial thromboplastin time) (a blood test that measures how long it takes for blood to clot) within normal limits. PT (prothrombin time) (a blood test that measures how long it takes for blood to clot) within normal limits. INR (international normalized ratio) (a blood test that measures how long it takes for blood to clot) within normal limits. CBC (completed blood count) (a routine blood test that measures the number of red blood cells, white blood cells, platelets, and hemoglobin and hematocrit levels) within normal limits. A review of Resident #23's abdominal ultrasound performed 11/19/25 at 8:00 AM revealed no subcutaneous (under the skin) fluid collection to left lower quadrant. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) was conducted on 11/19/25 at 11:22 AM. The DON reported that Resident #23 was administered Plavix and aspirin daily. Resident #23 had a large area of bruising noted to her left lower quadrant of abdomen initially noted on 11/15/25 by Unit Manager #1. Unit Manager #1 did not document measurements or assessment of the bruised area in Resident #23's electronic medical record. The NP was notified of the bruising and assessed Resident #23 in clinic on the morning of 11/17/25. The NP ordered blood work and an abdominal x-ray to be performed STAT on 11/17/25. The blood work had been performed and was within normal limits. The abdominal x-ray was performed the morning of 11/19/25 and the results were still pending at time of the interview. The DON stated that nurses should complete documentation of skin assessments when performed and complete a progress note in the electronic medical record. 2. Resident #105 was admitted to the facility on [DATE] with diagnoses which included trans-metatarsal amputation (surgical procedure to remove the forefoot including the metatarsal bone to preserve function of the foot) of the right foot, carbapenem resistant enterobacterales (CRE) (bacteria resistant to one or more antibiotics and could cause serious infection), and type 2 diabetes. Review of surgical wound treatment order for Resident #105 written by the Nurse Practitioner (NP) dated 10/27/25 revealed clean open wound at right foot amputation site with Dakins 0.25% (solution used for cleaning infected and contaminated wounds), pack with Dakins 0.25% fluffed gauze (cotton roll used to cushion wound and secure dressing in place), cover with dry dressing (dry absorbent pad used to cover wound), abdominal pads (ABD)(pads used to absorb discharges from heavily draining wounds) and Kerlix (sterile bandage used to provide protection and manage wound drainage), perform daily and as needed. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #105 was cognitively intact and required minimal assistance with activities of daily living. The assessment also revealed Resident #105 had surgical wound to the foot, nutrition, and hydration interventions to manage skin problems, surgical wound care, application of medications and dressings, no behaviors or refusals of care. Review of revised care plan dated 11/06/25 revealed Resident #105 had a surgical wound to the right foot and was at risk for infection and complications. Interventions included keeping skin clean and dry as possible, complete treatment as ordered, observing the site for any signs or symptoms of infection, and enhanced barrier precautions per order. Review of November 2025 nursing schedule and daily assignment sheet revealed Nurse #12 was assigned to Resident #105 during first shift (7:00 AM to 7:00 PM) on Saturday 11/01/25 and Saturday 11/08/25. Nurse #2 was assigned during first shift on Saturday 11/15/25. Review of the November 2025 Treatment Administration Record (TAR) revealed Resident #105's daily scheduled surgical wound care was not documented on Saturday 11/01/25, Saturday 11/08/25, and Saturday 11/15/25 as completed. Nurse #12 who was scheduled to work first shift on Saturday 11/01/25 and Saturday 11/08/25, assigned on both dates to Resident #105 was unable to be reached for an interview. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Resident #105 on (Sunday) 11/16/25 at 11:11 AM. He revealed that he had all of his right toes surgically removed, his right foot wound dressing was supposed to be changed daily, and the dressing had not been changed since Friday 11/14/25. He stated his wound was draining through his bandage and he needed his dressing changed. He revealed earlier this morning he had notified Nurse #2 that his wound was draining and he needed his dressing to be changed, and Nurse #2 had stated that she was not doing wound care and for him to find another nurse to do it. Resident #105 revealed that he currently had a bacterial infection and was afraid that his wound would become infected if his dressings were not changed daily. He stated that since he was admitted to the facility on [DATE], there had been times during the weekends when his wound dressing had not been changed and when he asked the nurse assigned to him (could not recall nurse's name) about changing his dressing they refused. Observation of Resident #105's wound dressing on his right foot revealed the top and bottom of the dressing covering the surgical wound to be soaked through with a wet brown discharge, areas of dried brown discharge, dated Friday 11/14/25, and initialed by the Wound Nurse. An interview with Nurse #2 on 11/16/25 at 11:20 AM revealed she had been assigned to Resident #105 yesterday 11/15/25 and today 11/16/25. She stated Resident #105 had asked her yesterday (11/15/25) and today (11/16/25) about changing his wound dressing but she was a contract nurse who had been working at the facility for one week and did not know anything about resident wound care orders or being responsible for providing wound care, had no plans to perform resident wound care, and any further questions regarding resident wound care could be directed to the Unit Manager. An interview was conducted with Unit Manager #1 on 11/16/25 at 11:25 AM. She stated the facility Wound Nurse performed resident wound care Monday through Friday and nursing staff were responsible for performing wound care scheduled for the evenings and on weekends. She revealed she was not aware of nursing staff refusing to perform wound care or resident wound care not being performed as ordered. UM #1 stated she would investigate why Resident #105's wound care had not been performed as ordered on the weekends and would speak with nursing staff immediately to ensure Resident #105's wound dressing was changed as soon as possible. An interview was conducted with the Nurse Practitioner (NP) on 11/18/25 at 1:29 PM. The NP revealed that she expected the facility nursing staff to follow her wound care orders as written. She stated she also expected the nursing staff to notify her with any questions or concerns regarding any resident's wound care orders and to inform her of any issues involving resident's wounds. The NP revealed Resident #105's wound care should be provided daily and as needed especially if the wound was draining to keep the wound from becoming infected. An interview on 11/19/25 at 9:31 AM with the Director of Nursing (DON). The DON stated she expected the wound treatments to be done as ordered. She stated she also expected that if nursing staff were not able to complete a wound treatment that they notify their nursing supervisor immediately. The DON revealed Resident #105 should have received his wound treatments daily and as needed per his wound orders. An interview was conducted with the facility's Medical Director on 11/19/25 at 4:53 PM. The Medical Director stated that he expected the nursing staff to follow physician orders for dressing changes and wound care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Administrator on 11/20/25 at 11:01 AM. The Administrator revealed that she expected nursing staff to follow all orders, procedures, and protocols for providing resident wound care and should have provided Resident # wound care as ordered. She stated if nursing staff had questions regarding wound care orders or were not able to provide a resident's wound care as ordered then she expected them to inform their supervisor immediately.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and Guardian, staff, Registered Dietician, Nurse Practitioner and Medical Director interviews, the facility failed to provide enteral feedings (method of delivering nutrition directly into the gastrointestinal tract through a feeding tube) per the physician orders for 1 of 3 residents reviewed for nutrition (Resident #63).The findings included: Resident #63 was admitted to the facility on [DATE]. Resident #63 had diagnoses that included diabetes mellitus (DM) type 2, anxiety, major depressive disorder, encounter for attention to gastrostomy (artificial opening in the stomach). Resident #63 had a physician's order dated 6/29/2024 for enteral feeding (method of delivering nutrition directly into the gastrointestinal tract through a feeding tube) for nutren 2.0 (feeding formula) at 46 milliliters (ml)/hour (hr) administered continuously from 9:00 PM to 9:00 AM daily. Resident #63 had a physician's order dated 6/29/2024 for blood sugar checks four times daily before meals and at bedtime for DM. Resident #63 had a physician order dated 2/26/2025 for Lantus (long-acting insulin) inject 20 units subcutaneously at bedtime for diabetes mellitus if Capillary Blood Glucose (CBG) less than 65 only give 10 units. Notify provider if Capillary Blood Glucose (CBG) is less than 60 or greater than 450. This order was discontinued on 10/15/2025 and a new order was written. Review of Resident #63's care plans last revised on 2/27/2025 revealed:Resident was at risk for complications related to the need for an enteral tube feeding secondary to dysphagia and poor po intake with interventions that included check for residual prior to feeding administration, if greater than 120 milliliters (ml) hold feeding for 1 hour and recheck. If residual amount remains over 120ml call provider for further instruction. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #63 had severe cognitive impairment, indicated Resident #63 had a feeding tube, and received a mechanically altered and therapeutic diet and received 51% or more of diet and 501 cubic centimeters (cc)/day or more of fluid through a feeding tube, and weighed 95 lbs. A progress note dated 8/1/2025 written by Nurse #3 revealed Resident #63's blood glucose was 335 milligram/deciliter (mg/dl), tube feeding stopped early to help blood glucose stabilize. During a telephone interview on 11/17/2025 at 4:56 PM Nurse #3 revealed she worked at the facility on the 7:00 PM to 7:00 AM shift and was familiar with Resident #63. Nurse #3 confirmed she had turned off Resident #63's tube feeding early due to high blood sugar on the morning of 8/1/2025. Nurse #3 stated she thought it was nursing judgement. Nurse #3 stated she thought it would be better for the resident to have the tube feeding stopped than have an elevated blood sugar. Nurse #3 would not verify if this was the only time she turned Resident #63's tube feeding off early. On 10/3/2025 Resident #63's had a new physicians order for enteral feeding nutren to increase flow rate by 10ml every 24 hours to a goal rate of 65ml/hr from 9:00 PM to 9:00 AM. During an interview on 11/19/2025 at 8:20 AM Nurse #1 stated she had worked at the facility since September 2025 and currently worked the 7:00 PM to 7:00 AM shift and was familiar with Resident #63. Nurse #1 stated one night in October 2025, she did not recall the specific date, she was concerned about Resident #63 having a high blood sugar over 400, and that it would continue to get higher, and no orders for insulin sliding scale coverage. Nurse #1 stated she asked another nurse, she could not remember which one, what to do and the nurse told her to turn off the tube feeding. Nurse #1 stated she thought the nurse that had told her to turn off the tube feeding, had been turning off the tube feeding early due to high blood sugars, so Nurse #1 turned off Resident #63's tube feeding. Nurse #1 stated she did not document in the electronic medical record or on the MAR that Resident #63's tube feeding had been turned off early. Nurse #1 stated she had reported it to Unit Manager #4 who told her not to turn a resident's tube feeding off early, and no one else talked to her about it. Nurse #1 stated at the time she was more worried that the elevated blood sugar could cause a seizure. During a telephone interview on 11/17/2025 at 10:00 AM, Resident #63's Guardian stated she had concerns that Resident #63's tube feeding was not running the full length of time it was ordered and discussed weight loss Resident #63 experienced. Resident #63's Guardian stated on several visits to Resident #63 around 9:00 AM in morning, the tube feeding was not running. Resident #63's Guardian stated she spoke to the Director of Nursing (DON), a unit manager and the Nurse Practitioner (NP #2) regarding her concerns and did not feel Resident #63's tube feeding had been monitored until she spoke to the facility after Resident #63 experienced weight loss. During a telephone interview on 11/18/2025 at 7:05 AM Unit Manager #4 stated sometime around mid-October Nurse #1 reported to Unit Manager #4 that Resident #63's tube feeding had been held due to high blood sugar, and that other nurses had done it since Resident #63 had no insulin orders for sliding scale coverage for elevated blood sugars. Unit Manager #4

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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 observations, record reviews, and Nurse Practitioner and staff interviews, the facility failed to obtain a physician's order for a resident who was admitted from the hospital on continuous oxygen (Resident #126). The facility also failed to post cautionary signage outside of resident rooms that indicated the use of oxygen for 1 of 5 residents reviewed for respiratory care (Resident #126).Findings included: Resident #126 was admitted on [DATE] with diagnoses that included pneumonia.A review of Resident #126's admission orders revealed that Unit Manager #2 completed the admission.Resident #126's physician orders revealed no order for oxygen use. Resident #126's admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #126 was admitted [DATE] and MDS was in progress at time of review. No oxygen or respiratory information was complete. A review of Resident #126's care plan updated on 11/14/25 revealed a plan for risk of respiratory complications. The stated goal was that Resident #126 would be free from respiratory complications. Interventions included administer oxygen as ordered, monitor for signs of respiratory distress, and check vital signs as needed. a. An observation of Resident #126 in her room on 11/16/25 at 12:41 PM revealed oxygen concentrator in use via nasal cannula at 2 liters per minute. A second observation of Resident #126 in her room on 11/17/25 7:54 AM revealed oxygen concentrator in use via nasal cannula at 2 liters per minute. A third observation of Resident #126 in her room on 11/18/25 7:42 AM revealed the oxygen concentrator in use via nasal cannula at 2 liters per minute. b. An observation of Resident #126 in her room on 11/16/25 at 12:41 PM revealed no cautionary oxygen in use signage was noted outside of Resident #126's room indicating oxygen was in use.A second observation of Resident #126 in her room on 11/17/25 7:54 AM revealed no cautionary oxygen in use signage outside of Resident #126's room indicating oxygen was in use.A third observation of Resident #126 in her room on 11/18/25 7:42 AM revealed no cautionary oxygen in use signage outside of Resident #126's room indicating oxygen was in use.An interview with Medication Aide #1 was conducted on 11/18/25 at 1:08 PM. Medication Aide #1 stated Resident #126 received oxygen continuously. Medication Aide #1 indicated, she did not see an order for oxygen on the medication administration record and indicated she did not know who was responsible for applying the oxygen in use cautionary signs to resident rooms. Medication Aide #1 verbalized she had not noticed that Resident #126 did not have an oxygen in use sign on door.An interview was completed with Unit Manager #2 on 11/20/25 at 7:47 AM. Unit Manager #2 revealed that she could not recall if she completed the admission orders for Resident #126. Unit Manger #2 stated that orders were received from the hospital via discharge paperwork and entered into facility electronic medical record. Unit Manger #2 stated there were many admissions that day, and she could not remember if she initiated Resident #126's oxygen or not. Unit Manager #2 stated whoever initiated the oxygen should have placed the cautionary signage on Resident #126's door. An interview with the Nurse Practitioner (NP) was completed on 11/18/25 at 2:28 PM. The NP stated that Resident #126 was admitted from the hospital, and any orders on discharge paperwork would be entered by the nurse admitting the resident. The NP stated that she assessed Resident #126 on Monday 11/17/25 and stated that she was on oxygen via nasal cannula at time of assessment. The NP stated that Resident #126 had no respiratory difficulty or shortness of breath on assessment. The NP stated she did not know how the order for oxygen got overlooked. An interview was conducted with the Director of Nursing (DON) on 11/20/25 at 10:19 AM. The DON stated that oxygen orders should have been in place for oxygen use for Resident #126 prior to initiating oxygen. The DON further stated that oxygen-in-use cautionary signage should be posted outside the doors of all residents' rooms who used continuous oxygen.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on record review and staff interviews, the facility failed to post accurate Registered Nurse (RN) staffing information for 10 of 79 days reviewed for posted nurse staffing (09/08/2025, 09/09/2025, 09/15/2025, 09/17/2025, 09/19/2025, 10/27/2025, 11/07/2025, 11/14/2025, 11/17/2025, and 11/18/2025).The findings included:The daily posted nurse staffing sheets were reviewed for the period of 09/01/2025 through 11/18/2025 and revealed the following:September 2025 did not have any RN documented as working for all 3 shifts on the following days: 09/08/2025, 09/09/2025, 09/15/2025, 09/17/2025, and 09/19/2025.October 2025 did not have an RN documented as working for all 3 shifts on the following day: 10/27/2025. November 2025 did not have any RN documented as working for all 3 shifts on the following days: 11/07/2025, 11/14/2025, 11/17/2025, and 11/18/2025.Review of employee timecard punches provided by the Administrator verified there had been RN coverage in the building for all the above dates and the RN staffing information posted was incorrect.During an interview on 11/19/2025 at 8:40 AM with the Scheduler, she stated she was responsible for the staff posting and she was unaware of the requirement to adjust the posted staffing information to reflect the actual staff present. She stated she completed the posted staffing sheets ahead of time based on the staff work schedule. She stated when she was off on the weekend or vacation, she completed the posted staffing sheets ahead of time and they were not adjusted to accurately reflect the actual staffing. During an interview on 11/19/2025 at 9:52 AM with the Administrator, she stated she was aware of the requirement to adjust the posted staffing to accurately reflect the actual staff present. She also stated she was unaware this was not being done, and the Scheduler did not know the posted staffing information should be updated with the actual staff on each shift.

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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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record reviews, observations, Consultant Pharmacist, and staff interviews, the facility failed to discard expired medications in 1 of 1 medication room, failed to store influenza vaccine per manufacturer recommendations, and failed to maintain a refrigerator temperature log for 2 of 2 refrigerators housing medications that required refrigeration.The findings included:1. An observation of the medication room was conducted on 11/19/2025 at 1:45 PM with the Director of Nursing (DON). The observation revealed one medication room that contained 2 small refrigerators. One on the upper counter and one on the lower counter. The observation revealed 8 unopened, expired bottles of magnesium citrate. The expired bottles of magnesium citrate were located on the bottom shelf in the medication storage room. A review of the manufacture's label affixed to the bottles of Magnesium Citrate indicated the expiration date was 10/9/2025 on all 8 bottles. During the observation the DON confirmed the expiration date and stated there should be no expired medications in the medication storage room or in the medication carts. She also stated the bottles of magnesium citrate should have been discarded. The DON further explained that all nursing staff were responsible for checking the medication rooms weekly for expired medications and the bottles of Magnesium Citrate should have been discarded. An interview was conducted with the Administrator on 11/19/2025 at 3:30 PM. The Administrator stated that she expected all expired medications to be discarded and not available for use. 2. Review of the manufacture's storage recommendations that were undated for Seqirus Influenza vaccines (the brand in both refrigerators) indicated that vaccines should be refrigerated between 36-46 degrees Fahrenheit and should not be frozen, any vaccine that is frozen should be discarded immediately. It was recommended that temperatures be checked and recorded in the storage units twice a day. An observation of the upper refrigerator and temperature logs for September 2025 was conducted on 11/19/25 at 1:45 PM revealed a temperature was recorded once daily for 10 out of 30 days, temperatures ranged from 38-42 degrees Fahrenheit. No temperatures were recorded for 20 out of 30 days. The refrigerator contained Seqirus influenza vaccines. These temperatures were within manufacturers' recommendations, but temperatures were not recorded twice daily as recommended. Further observation of the lower refrigerator and review of the logs for September 2025 revealed a temperature was recorded once daily for 10 out of 30 days, temperatures ranged from 38-42 degrees Fahrenheit. No temperatures were recorded for 20 out of 30 days. The refrigerator contained Seqirus influenza vaccines. These temperatures were within manufacturers' recommendations, but temperatures were not recorded twice daily as recommended. An observation of the upper refrigerator and temperature logs for October 2025 on 11/19/25 at 1:45 PM revealed a temperature was recorded once daily for 18 out of 31 days, temperatures ranged from 38-42 degrees Fahrenheit. No temperatures were recorded for 13 out of 31 days. The refrigerator contained Seqirus influenza vaccines. These temperatures were within manufacturers' recommendations, but temperatures were not recorded twice daily as recommended. Further observation of the lower refrigerator and review of logs for October 2025 revealed a temperature was recorded once daily for 18 out of 31 days, temperatures ranged from 38-42 degrees Fahrenheit. No temperatures were recorded for 13 out of 31 days. The refrigerator contained Seqirus influenza vaccines. These temperatures were within manufacturers' recommendations, but temperatures were not recorded twice daily as recommended. An observation of the upper refrigerator and temperature logs for November 2025 on 11/19/25 at 1:45 PM revealed temperatures had been recorded once a day for 2 out of 19 days on 11/10/25 and 11/11/25 and was at 32 degrees Fahrenheit on both days. No temperatures were recorded for 17 out of 19 days. The refrigerator contained Seqirus influenza vaccines. These temperature readings were outside of the manufacture's recommendations for storing these medications. Recommended temperature recordings of twice daily were also not being followed for the month of November. Further observation of the lower refrigerator and review of November 2025 logs revealed temperatures had been recorded once a day for 2 out of 19 days on 11/10/25 and 11/11/25 and was at 32 degrees Fahrenheit on both days. No temperatures were recorded for 17 of 19 days. The refrigerator contained Seqirus influenza vaccines. These temperature readings were outside of the manufacture's recommendations for storing these medications. Recommended temperature recordings of twice daily were also not being followed for the month of November. Observation of the Seqirus influenza vaccine vials revealed vials with clear liquid that had no free-floating particles and no evidence that the liquid had been frozen. An interview was conducted with the Director of Nursing (DON) 11/19/25 at 1:45 PM that indicated she expected staff to record temperatures twice a day, for both refrigerators and report to

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to clean 1 of 2 ice machines (the dining room ice machine). This practice had the potential to affect beverages served to residents.The findings included:During the initial tour of the kitchen on 11/16/2025 at 9:40 AM an observation of the dining room ice machine was conducted with the Dietary Manager (DM). The observation revealed a black substance located on the plastic splash guard above the ice. The substance was not in contact with the ice in the ice machine.During an interview with the DM on 11/16/2025 at 10:15 AM, the DM stated the ice machine was less than six months old was still under warranty and the first full deep clean was scheduled for 12/01/2025 and then would be completed every 6 months. The DM stated maintenance was responsible for completing a wipe down cleaning of the ice machines monthly, but a new Maintenance Supervisor just recently started at the facility. The DM stated she expected the ice machine to be free of any black substances. The Maintenance Supervisor was in training and not available for interview.During an interview on 11/20/2025 at 6:45 AM the Administrator stated a new Maintenance Supervisor had been recently hired and the ice machines may not have been cleaned on schedule prior to the recent hire. The Administrator stated she expected the ice machine to be cleaned routinely.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and Nurse Practitioner (NP), Local Health Department Nurse, State Health Department, staff and resident interviews, the facility failed to implement their infection control policy and procedures for enhanced barrier precaution (EBP) for a resident who was positive for Carbapenem Resistant Enterobacterial (CRE) (bacteria resistant to one or more antibiotics and could cause serious infection). In addition, the facility failed to immediately implement health department recommendations to initiate the process to test other residents for CRE. This deficient practice was identified for 1 of 6 residents observed for infection control practices and had the potential to affect other residents (Resident #105). The findings included: Review of revised facility enhanced barrier precautions (EBP) policy dated 3/26/24 revealed this policy might be indicated for residents known to be colonized or infected with bacterial organisms to include carbapenem resistant enterobacterial (CRE) (bacteria resistant to one or more antibiotics and could cause serious infection), surgical wounds, and indwelling medical devices. The policy also revealed the EBP policy required the use of personal protective equipment (PPE), hand hygiene, and EBP signage to be placed on the wall or door outside of resident's room. Resident #105 was admitted to the facility on [DATE]. Review of Resident #105's preliminary lab results for right foot wound culture dated 10/31/25 revealed the culture obtained on 10/27/25 was positive for carbapenem resistant enterobacterial (CRE). Review of NP order dated 10/31/25 received by the Director of Nursing (DON) for Resident #105 to be placed on enhanced barrier precautions for wound infection. Review of Resident 105's final lab results received from the local county health department dated 11/13/25 revealed Resident #105's right foot wound culture obtained on 10/27/25 was positive for CRE. Recommendations included immediate placement of resident on enhanced barrier precautions and further screening of residents to ensure no colonization. Review of nursing note dated 11/13/25 written by Nurse #3 indicated a return phone call was made to the communicable disease nurse from the local county health department and was informed Resident #105's right foot wound sample came back positive for CRE. NP was made aware. An interview was conducted with Nurse #3 on 11/18/25 at 4:00 PM. Nurse # revealed that she was working first shift on Thursday 11/13/25 and had received a telephone call from the nurse at the local health department stating Resident #105's final wound culture was available and had been faxed over to the facility and that he was positive for CRE. She stated she made a note in Resident #105's electronic medical record, retrieved the paper copy of the results off the fax, made copies of the results, and placed the copies of the results in the DON and the NP's box for review. Nurse #3 stated she did not review the results herself and was not aware of the recommendations. She revealed she had not been made aware of Resident #105's precautions status and that typically nursing staff were not notified of a resident's precautions status unless they had received the order for the resident to be placed on precaution or happened to see the order in the chart. She stated typically the only way staff are made aware of when a resident was placed on precautions for whatever reason was by the precaution signage placed on their door and if a resident did not have precautions signage on their door, then it was assumed they were not on any type of precautions. An interview and observation were conducted with Resident #105 inside of his room on 11/16/25 at 11:11 AM. He revealed that he recently had all his toes on his right foot surgically removed, his wound was currently draining and required daily wound care and was positive for a bacterial infection from his wound. Observation of Resident #105's wound dressing on his right foot revealed the top and bottom of the dressing covering the surgical wound to be soaked through with a wet brown discharge and areas of dried brown discharge. There was no barrier precaution signage located on or outside of Resident #105 door and no PPE present. An interview was conducted with Unit Manager #1 on 11/16/25 at 11:25 AM. Unit Manager #1 stated Resident #105 should have already been placed on enhanced barrier precautions, he was admitted with a surgical wound that required wound care, had an order for enhanced precautions from the NP, and was also positive for a bacterial wound infection. She revealed she was on her way to place the enhanced precautions on Resident #105 door and that it was nursing staff responsibility to make sure all residents' orders were followed, residents were placed on the correct precautions, and that all staff were informed of resident's precaution status. An interview was conducted with Wound Nurse on 11/17/25 at 10:45 AM. The Wound Nurse stated that to her knowledge all residents requiring wound care were on enhanced barrier precautions to help prevent the spread of any bacteria and reduce infections. She revealed she was not aware and had not even noticed that Resident #105 was not on enhanced barrier