STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Greens at Gastonia	969 Cox Road Gastonia, NC 28054

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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and resident and staff interviews, the facility failed to maintain residents' dignity when staff failed to knock before entering residents' rooms and when staff spoke negatively about a resident in the hall for 3 of 3 residents reviewed for dignity and respect (Resident #47, Resident #48 and Resident #90). The residents stated they felt very frustrated, angry, embarrassed, hurt and not worthy of respect or care. The findings included: a. Resident #47 was admitted on [DATE].Resident #47's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. An observation conducted during the initial tour on 6/22/26 at 10:45 AM revealed Nurse Aide (NA) #1 approaching the room of Resident #47, the door was closed, NA#1 proceeded to turn the door handle without knocking and entered the room.An interview with Resident #47 was conducted on 6/25/26 at 11:19 AM. Resident #47 reported the staff came into his room without knocking frequently. He stated he did not like it when they did this and became very frustrated. He reported he felt like he was entitled to have privacy. Resident #47 stated he had asked staff to knock before entering several times, but he had not made a complaint to management staff about staff not knocking.b. Resident #90 was admitted to the facility on [DATE].Resident #90 quarterly MDS assessment dated [DATE] revealed Resident #90 was cognitively intact.An observation conducted on 6/24/26 at 2:15 PM revealed NA #1 going into Resident #90's room. NA #1 approached the closed door of Resident #90's room, proceeded to turn the door handle without knocking and entered the room. An interview was conducted on 6/25/26 at 11:08 AM with Resident #90. He reported the staff came into his room several times a day without knocking. He reported that the staff had even come into the bathroom while he was in there, without knocking before. Resident #90 stated that when the staff comes into his room without knocking it makes him feel angry and like he has no privacy.An interview was conducted with Nurse Aide #1 at 2:07 PM on 6/25/26. She reported she was recently educated on privacy, including knocking on the resident's door and announcing yourself and waiting until the resident tell us to come in. She stated she felt like she didn't consistently knock on doors before entering resident rooms. She reported that she got caught up in her task and would forget to knock. She stated she did not remember if she knocked going into Resident #90 or Resident #47's room on 6/22/26 or 6/24/26.Resident #90 and Resident #47 did not reside in the same room.c. Resident #48 was admitted to the facility on [DATE].The quarterly minimum data set (MDS) dated [DATE] revealed Resident #48 was cognitively intact.An interview was conducted on 6/24/26 at 1:15 PM with Resident #48. Resident #48 revealed that back in February of 2026 she had told NA#2 that her lunch meal plate appeared to have coffee grounds on it. She reported NA #2 took the plate and told her she would have it replaced. Resident #48 reported that when NA#2 went out into the hall with the plate Nurse #5 asked her what was wrong with the plate and the NA #2 told him about Resident #48's concern. Resident #48 stated she heard Nurse #5 say to NA#2 in a sing-song tone, that she had H. I. V. and thinks she can complain about everything. Resident #48 indicated that Nurse #5 never used her name, but she knew he was talking about her, and she felt so embarrassed and hurt. Resident #48 reported that the comment made her feel like, that because of (continued on next page)

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

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

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F 0550 Level of Harm - Actual harm Residents Affected - Few	her diagnosis she was not worthy of his respect or care. An interview was conducted with NA #2 on 6/25/26 at 9:34 am. NA #2 reported that she remembered Resident #48 was concerned her lunch meal plate was dirty in February and she had offered to get her a new one. She stated that when she came out of the room with the plate, Nurse #5 asked her what was wrong with the plate. She stated she told him it was dirty and she was going to get Resident #48 another tray. NA #2 reported that Nurse #5 said to her that Resident #48 had H. I. V. and thought that gave her the right to complain about everything. NA #2 indicated Nurse #5 did not say Resident #48's name but they were standing just outside of Resident #48's room. NA #2 revealed that when she returned to Resident #48's room she was visibly upset and told NA #2 that she overheard what Nurse #5 said and it really hurt her. NA #2 reported she notified the Director of Nursing (DON).Nurse #5 was not available for interview and was no longer employed at the facility.An interview with the Director of Nursing (DON) was conducted on 6/25/26 at 6:50 PM. The DON reported that she expected her staff to knock on the door before entering. She reported that staff received training on residents' rights upon hire and annually and had recently received training specifically about knocking on room doors before entering. She explained that she was not sure why any staff would enter a resident's room without knocking and waiting for permission from residents who were cognitively able to give that permission. The DON revealed that she did not remember anyone reporting to her the incident involving Resident #48 and Nurse #5, regarding him speaking disrespectfully about Resident #48. She reported she expected all staff to treat all residents with respect and not discuss resident diagnoses with others and not to belittle a resident due to a diagnosis.An interview with the Administrator was conducted on 6/25/26 at 7:30 PM. The Administrator indicated that he expected all staff to knock on the door of a room, announce themselves, and wait for the residents' permission before entering a resident's room. He reported that staff received training on residents' rights and should know they were required to knock and wait for permission before entering a resident's room. The Administrator reported he had no knowledge of the incident involving Resident #48 and Nurse #5. He reported he expected all staff to always be professional and respectful.

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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 - Some	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, resident, Resident Representative, staff, Consulting Pharmacist, and Medical Director interviews, the facility failed to obtain consent and inform the resident or Resident Representative in advance of the risks and benefits of psychotropic medications prior to the initiation or increase of the medication for 4 of 5 residents reviewed for unnecessary medications (Resident #15, Resident #47, Resident #27, Resident #1).The findings included:a. Resident #15 was admitted on [DATE] with diagnosis that included schizophrenia, psychophysical visual disturbance, Alzheimer's, Dementia with behavioral disturbance, anxiety disorder and other recurrent depression disorder.Resident #15's physician's orders revealed an active order dated 1/5/2026 mirtazapine (antidepressant medication that is also prescribed off-label for anxiety and appetite stimulant) 7.5 milligram (mg) tablet give 1 tablet by mouth at bedtime for anxiety/appetite.Resident #15's physician's orders revealed an order dated 1/5/2026 for olanzapine (antipsychotic medication) 10mg give 1 tablet by mouth two times a day for depression. This order was discontinued on 1/23/2026. Resident #15's physician's orders revealed an order dated 1/23/2026 for olanzapine 10mg give 1 tablet by mouth at bedtime for depression. This order was discontinued on 4/9/2026.Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #15 was severely cognitively impaired, and indicated Resident #15 received an antipsychotic and an antidepressant during the 7 day look back period.Resident #15's physician's orders revealed a discontinued order dated 2/28/2026 for buspirone hcl (antianxiety medication) 10mg give 1 tablet by mouth two times a day for anxiety. This order was discontinued on 5/21/2026.Resident #15's physician's orders revealed an active order dated 4/9/2026 for olanzapine 7.5mg give 1 tablet by mouth at bedtime for depression. Resident #15's physician's orders revealed an active order dated 5/21/2026 for buspirone hcl 10mg give 1 tablet by mouth three times a day for anxiety.Review of Resident #15's Medication Administration Record (MAR) from January to June of 2026 revealed mirtazapine, olanzapine and buspirone hcl was administered as ordered.A review of Resident #15's medical record revealed no information indicating if Resident #47 was informed in advance of the risks and benefits of mirtazapine, olanzapine and buspirone.An interview was conducted on 6/25/2026 at 11:10 AM with Resident #15's Resident Representative, who verified he had not been informed of any risks or benefits or side effects of mirtazapine, olanzapine or buspirone by the facility and had not signed any psychotropic consents for Resident #15.An interview with Medical Director #2, who was assigned to Resident #15, was conducted on 6/25/2026 at 10:42 AM. Medical Director #2 stated the facility was responsible for obtaining consent for psychotropic medications for residents who started and/or had an increase in dose for psychotropic medication. b. Resident #47 was admitted on [DATE] with diagnosis that included depression and generalized anxiety disorder.Resident #47's physician's orders revealed a discontinued order dated 10/29/2025 for trazodone (antidepressant medication that is also prescribed off label as a non-habit-forming sleep aid for insomnia) 50mg give one by mouth at bedtime for insomnia.Resident #47's physician's orders revealed a discontinued order dated 11/3/2025 for trazodone 100mg give one by mouth at bedtime for insomnia.Resident #47's quarterly MDS dated [DATE] revealed Resident #47 was cognitively intact and indicated antianxiety medication was administered during the 7 day look back period.Review of Resident #47's MAR from October 2025 through June 2026 revealed trazodone was administered as ordered.A review of Resident #47's medical record revealed no signed consent indicating Resident #47 was informed in advance of the risks and benefits of trazodone.An interview with Resident #47 was conducted on 6/24/2026 at 11:00 AM. Resident #47 stated he had not been informed of the risk or benefits of trazodone by anyone at the facility and had not signed a psychotropic medication consent.c. Resident #27 was admitted on [DATE] with diagnosis that included major depressive disorder, generalized anxiety disorder.Resident #27's physician's orders revealed an order dated 5/8/2025 for mirtazapine (antidepressant (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication) 7.5mg give 1 tablet by mouth at bedtime for depression. This order was discontinued on 5/22/2025.Resident #27's physician's orders revealed an order dated 5/22/2025 for mirtazapine 15mg give 1 tablet by mouth at bedtime related to depression. This order was discontinued on 8/15/2025.Resident #27's physician's orders revealed an order dated 8/15/2025 for mirtazapine 15mg give 1 tablet by mouth at bedtime related to major depressive disorder. This order was discontinued on 9/3/2025.Resident #27's physician's orders revealed an active order dated 9/3/2025 for mirtazapine 15mg give one tablet by mouth at bedtime related to depression.Resident #27's annual MDS dated [DATE] revealed Resident #27 was cognitively intact and indicated she had received antidepressant and antianxiety medication during the 7 day look back period.Review Resident #27's MAR from 5/8/2025 through June 2026 revealed mirtazapine was administered as ordered.A review of Resident #27's medical record revealed no information indicating if Resident #47 was informed in advance of the risks and benefits of Mirtazapine.An interview was conducted on 6/25/2026 at 10:05 AM with Resident #27. Resident #27 stated no one from the facility had informed her of the risk and benefits of mirtazapine and she had not signed a psychotropic medication consent.d. Resident #1 was admitted on [DATE] with diagnosis that included depression, insomnia and anxiety.Resident #1's physician's orders revealed an order dated 4/24/2026 for fluoxetine (antidepressant medication) 10mg give 1 by mouth daily for depression, anxiety and sexually inappropriate behavior. This order was discontinued on 5/8/2026.Resident #1's physician's orders revealed an order dated 5/8/2026 for fluoxetine 20mg give 1 by mouth daily for depression/anxiety. This order was discontinued on 5/22/2026.Resident #1's physician's orders revealed an order dated 5/22/2026 for fluoxetine 40mg give 1 by mouth daily for depression. This order was discontinued on 6/19/2026.Resident #1's physician's orders revealed an active order dated 6/19/2026 for fluoxetine 60mg give 1 by mouth daily for depression/anxiety.Review of Resident #1's annual MDS dated 1/5/2026 revealed Resident #1 was cognitively intact and indicated he received an antidepressant during the 7 day look back period.Review of Resident #1's MAR from April to June 2026 indicated fluoxetine was administered as ordered.A review of Resident #1's medical record revealed no information indicating if Resident #47 was informed in advance of the risks and benefits of fluoxetine.An interview was conducted on 6/25/2026 at 2:00 PM with Resident #1, who stated he had not been informed of the risk and benefits of fluoxetine and had not signed a psychotropic medication consent. An interview was conducted with Nurse #1 on 6/24/2026 at 10:30 AM. Nurse #1 stated she thought the unit managers or supervisors completed the psychotropic medication consent forms.An interview was conducted with Unit Manager #2 on 6/24/2026 at 4:00 PM. Unit Manager #2 stated residents with orders for psychotropic medications needed a psychotropic consent form completed when they were admitted with orders for psychotropic medication and if a new psychotropic medication was started or the dose of a psychotropic medication was increased.A telephone interview was conducted on 6/25/2026 at 1:05 PM with the Psychiatric Nurse Practitioner (NP), who stated the facility was responsible for obtaining psychotropic medication consents for residents who started or had a dose increase of psychotropic medication.An interview was conducted with the Medical Director #1 on 6/25/2026 at 12:05 PM. Medical Director #1 revealed he did not complete psychotropic medication consents with the residents, and the facility was responsible for making sure they were completed per policy.A telephone interview with the Consulting Pharmacist on 6/25/2026 at 1:09 PM. The Consulting Pharmacist verified psychotropic medications required consent prior to being initiated and when there was a dose increase.An interview was conducted on 6/25/2026 at 11:29 AM with the Director of Nursing (DON) who stated a psychotropic consent form was required any time a resident started a psychotropic medication and when a psychotropic medication dose was increased. The DON revealed the floor nurses or unit manager should complete the consent when the order was received prior to administration of the first dose. The DON stated she was aware there was an issue with psychotropic consents not being complete, and the staff responsible to update consents had gone out on leave and the facility was still working on updating psychotropic medication consents.An interview was (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conducted on 6/25/2026 at 2:00 PM with the Administrator who stated he was not familiar with the exact process of psychotropic medication consents. The Administrator revealed the DON and nursing were responsible for psychotropic medication consents. The Administrator indicated he expected psychotropic medication consents to be completed by policy.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, Responsible Party, and Medical Director interviews, the facility failed to maintain accurate advanced directives throughout the medical record for 1 of 1 resident reviewed for advanced directives (Resident #103).The findings included:Resident #103 was admitted to the facility on [DATE].Review of Resident #103's comprehensive care plan initiated [DATE] indicated Resident #103 was a full code. Care plan goals listed as: Allow extra time for resident to discuss feelings regarding full code status, call 911 immediately as indicated, effectively communicate full code status wishes by placing in resident's chart, and or when resident must be transferred outside of the facility, Intercede rapidly and begin immediate resuscitative efforts utilizing all life-sustaining measures available if the residents heart stops beating or the resident stops breathing (Such as CPR, O2 administration etc.), notify family of residents condition promptly, obtain vital signs as ordered per physicians orders and as needed, notify provider as indicated.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #103 was severely cognitively impaired. Review of Resident #103's Physician's orders, revealed an order dated [DATE] that read Do Not Resuscitate- DNR (DNR). Review of the Code Book (a binder that contained paper copies of residents' advanced directives and code status) revealed Resident #103's paper medical record contained a signed Medical Orders for Scope of Treatment (MOST) form that indicated Resident #103's preference for DNR status in the event he had no pulse and was not breathing. The form was signed by Resident #103's Responsible Party and dated [DATE]. Review of the profile page of Resident #103's electronic health record revealed Resident #103's code status was listed as a DNR. An interview was conducted on [DATE] at 11:24 AM with Resident #103's Responsible Party who verified she had changed Resident #103's code status from a Full Code to a DNR on [DATE].An interview was conducted on [DATE] at 11:54 AM with Unit Manager #1 who revealed when a resident's code status was changed, she was responsible for entering the new order into the electronic medical record after all documentation was completed and signed. Unit Manager #1 did not recall who notified her of the change in Resident #103's code status. Unit Manager #1 confirmed the DNR form and MOST form were completed and signed on [DATE]. Unit Manager #1 stated she was not responsible for updating the residents care plan and revealed the MDS nurses updated the care plan. Unit Manager #1 stated that MDS nurses were notified of new orders for change in code status during the morning clinical meetings.An interview was conducted on [DATE] at 12:04 PM with MDS Nurse #1, who verified Resident #103's code status was listed as DNR, but the care plan indicated full code. MDS Nurse #1 stated changes or new orders for resident's code status were supposed to be communicated to MDS nurses in morning clinical meetings or by email. MDS Nurse #1 confirmed she was responsible for updating the residents care plan when their code status changed. MDS Nurse #1 stated Resident #103's care plan should have been updated after the new order for a DNR was received on [DATE]. MDS Nurse #1 was unsure of the exact reason Resident #103's care plan had not been updated. MDS Nurse #1 could not recall if Resident #103's new code status was discussed in the morning clinical meeting. An interview was conducted on [DATE] at 12:00 PM with the Director of Nursing (DON), who explained when a resident had a change in code status it was reported to the MDS nurses during the morning clinical meeting that was held Monday through Friday. The DON revealed the MDS nurses were responsible for updating the care plan when a resident had a change in code status. The DON could not recall if Resident #103's new code status had been discussed during the morning clinical meeting. The DON stated she expected a resident's code status to be consistent throughout the entire medical record.During an interview on [DATE] at 12:10 PM the Administrator indicated he was not familiar with the exact process that occurred when a resident had a change in code status. The Administrator stated he expected a resident's code status to be accurate and consistent throughout (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the entire medical record.An interview was conducted on [DATE] at 12:05 PM with the Medical Director who confirmed a resident's code status should be accurately documented throughout the entire medical record.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident, staff and Medical Doctor interviews, the facility failed to provide a treatment as ordered by the physician for a moisture associated skin issue for 1 of 3 residents reviewed for non-pressure skin treatments (Resident #48). The findings included:Resident #48 was admitted to the facility on [DATE] with diagnosis that included polyneuropathy (the malfunction or damage of multiple peripheral nerves throughout the body) generalized anxiety disorder, chronic obstructive pulmonary disorder, major depressive disorder. The quarterly minimum data set (MDS) dated [DATE] revealed Resident #48 was cognitively intact, incontinent of urine, and had moisture associated skin damage.A physician's order for Resident #48 dated 6/19/26 read, cleanse areas under abdominal folds with soap and water, pat dry. Apply interdry sheet (an antimicrobial, moisture-wicking fabric designed to manage moisture, friction and odor in skin folds) once daily.A review of the Treatment Administration Record (TAR) for June 2026 revealed documentation on 6/21/26 by Nurse #3 that Resident #48's interdry was applied.A review of the Treatment Administration Record (TAR) for June 2026 revealed documentation on 6/22/26 by Nurse #3 that Resident #48's interdry was applied.A review of the Treatment Administration Record (TAR) for June 2026 revealed documentation on 6/23/26 by Nurse #4 that Resident #48's interdry was applied.An interview was conducted with Resident #48 on 6/23/26 at 2:15PM. Resident #48 revealed that she had been prescribed interdry to help with moisture in her abdominal folds. She reported the hospital had sent interdry with her to the facility and it had been stored in her room, but she had ran out and had not received it for several days. She reported that the nurse aides had put a dry bath towel in her abdominal folds since she was out of the interdry. An observation of Resident #48's abdominal folds on 6/23/26 at 2:30 PM revealed that a bath towel had been placed in the abdominal fold.A second observation of Resident #48's abdominal folds on 6/23/26 at 4:15 PM with the Director of Nursing (DON) showed a bath towel had been placed in the abdominal folds and was now saturated with urine. During the observation the DON removed the towel from the abdominal fold and intact skin between the folds was observed.An interview was conducted with the Director of Nursing (DON) on 6/23/26 at 4:15 PM. The DON indicated she was not aware that Resident #48 was out of interdry and would have expected the nursing staff to make someone aware. She reported that the interdry had not been ordered but was available through the facility's vendor. She stated that after being made aware on 6/23/26 that Resident #48 did not have anymore, she had sent an employee to a sister facility to get some and made the supply clerk aware that interdry needed to be ordered. The DON stated that the nurses were aware that if there was a treatment on the TAR they do not sign it as completed unless they actually performed the treatment. The DON reported that putting a towel in Resident #48's abdominal folds was not an acceptable replacement for the interdry. An interview was conducted with the Treatment Nurse on 6/23/26 at 3:30 PM. The Treatment Nurse reported that she was not normally responsible for treatments such as placing or applying interdry, creams or powders. She stated she was, however, aware of the interdry order for Resident #48 only because she and Resident #48 had talked about it. She indicated she was not aware Resident #48 was out of the interdry. She stated the last time she was in Resident #48's room there was a box of interdry in there. An observation on 6/23/26 at 3:45 PM of the medication cart assigned to the hall where Resident #48 resided revealed no interdry was on the cart. An observation on 6/23/26 at 3:50 PM of the treatment cart revealed no interdry was on the cart. An observation on 6/23/26 at 3:55 PM of both medication storage rooms revealed no interdry in either room.An interview with Nurse #3 was conducted on 6/23/26 at 2:50 PM. Nurse #3 stated she had worked with Resident #48 on 6/21/26 and 6/22/26 and she did not know what interdry was. She reported she was newly hired at the facility and she felt she had signed the order as being completed on the TAR in error. Nurse #3 stated she did not apply interdry to Resident #48's abdominal folds.An interview with Nurse #4 was conducted on 6/23/26 at 3:00 PM. Nurse #4 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she was not aware of an order for Resident #48 that included interdry. She stated she did not apply interdry to Resident #48's abdominal folds during her shift. Nurse #4 reported she must have signed the order as being completed on the TAR by accident.An interview with the Medical Doctor (MD) was conducted on 6/25/26 at 10:30 AM. The MD revealed that he would expect to be notified if supplies for a treatment were not available and that an order should not be signed off on the TAR as completed if it was not performed. He reported that a bath towel could serve as a temporary replacement for the interdry, if the interdry was not available but should not be used long term as there were much more appropriate substitutes for interdry. The MD reported that a bath towel should be moistened prior to applying it to the abdominal folds to avoid skin breakdown.An interview was conducted with the Administrator on 6/25/26 at 7:15 PM. The Administrator revealed he would expect the nursing staff to make a manager aware if supplies for treatment was not available. He stated that if a nurse did not perform a treatment, then it should not be signed off on the TAR.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Medical Doctor and staff interviews, the facility failed to maintain an accurate Treatment Administration Record (TAR) for 1 of 3 residents reviewed for medical record accuracy (Resident #48).Findings included: Resident #48 was admitted to the facility on [DATE] with diagnosis that included polyneuropathy (the malfunction or damage of multiple peripheral nerves throughout the body) generalized anxiety disorder, chronic obstructive pulmonary disorder, major depressive disorder. The quarterly minimum data set (MDS) dated [DATE] revealed Resident #48 was cognitively intact and had moisture associated skin damage. A physician's order for Resident #48 dated 6/19/26 read, cleanse areas under abdominal folds with soap and water, pat dry. Apply interdry sheet (an antimicrobial, moisture-wicking fabric designed to manage moisture, friction and odor in skin folds) once daily. A review of Resident #48's June 2026 Treatment Administration Record (TAR) revealed that interdry had been signed by staff each day from 6/20/26 through 6/22/26, indicating it the interdry was applied to Resident #48's abdominal fold on these days. An interview was conducted with Resident #48 on 6/23/26 at 2:15PM. Resident #48 revealed that she had been prescribed interdry to help with moisture in her abdominal folds. She reported the hospital had sent interdry with her to the facility and it had been stored in her room, but she had ran out and had not received it for several days. She reported that the nurse aides had put a dry bath towel in her abdominal folds since she was out of the interdry. An observation of Resident #48's abdominal folds on 6/23/26 at 2:30 PM revealed that a bath towel had been placed in the folds. A second observation of Resident #48's abdominal folds on 6/23/26 at 4:15 PM with the Director of Nursing (DON) showed a bath towel had been placed in the abdominal folds and was now saturated with urine. An interview was conducted with the Director of Nursing (DON) on 6/23/26 at 4:15 PM. The DON stated that the nurses were aware that if there was a treatment on the TAR they do not sign it as completed unless they actually performed the treatment. An interview with Nurse #3 was conducted on 6/23/26 at 3:00 PM. Nurse #3 stated she had worked with Resident #48 on 6/21/26 and 6/22/26 and she did not know what interdry was. She reported she was newly hired at the facility and she felt she had signed the order as being completed on the TAR in error. Nurse #3 stated she did not apply interdry to Resident #48's abdominal folds. An interview with Nurse #4 was conducted on 6/23/26 at 3:30 PM. Nurse #4 stated she was not aware of an order for Resident #48 that included interdry. She stated she did not apply interdry to Resident #48's abdominal folds during her shift. Nurse #4 reported she must have signed the order as being completed on the TAR by accident. An interview with the Medical Doctor (MD) was conducted on 6/25/26 at 10:30 AM. The MD revealed that he would expect that an order would not be signed off on the TAR as completed if it was not performed. An interview was conducted with the Administrator on 6/25/26 at 7:15 PM. The Administrator revealed he would expect the nursing staff to only sign off on the TAR on treatments that were actually performed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. Building B. Wing	06/25/2026

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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 observations, record review, and staff interviews, the facility failed to follow their Hand Hygiene policy when Nurse #1 did not perform hand hygiene before each donning of clean gloves during catheter care and failed to perform hand hygiene between residents during medication pass. This deficient practice affected 3 of 7 residents reviewed for infection control and included 1 of 7 staff observed for infection control. (Resident #112, #121, #135). The findings included:Review of the facility's policy and procedure entitled Hand Hygiene read in part:Hand hygiene continues to be the primary means to prevent the spread of healthcare-associated infections. The following is a list of some situations that require hand hygiene:Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure, and lifting a resident);After contact with a resident's mucous membranes and body fluids or excretions;After handling soiled or used linens, dressings, bedpans, catheters, and urinals;After removing gloves or aprons; andAfter completing duty. An observation of catheter care was made on 6/24/26 at 11:15 AM with Resident #112 and Nurse #1. Nurse #1 was observed cleaning the bedside table and placing catheter supplies on a clean paper towel after the surface dried. Nurse #1 donned a clean gown and sanitized her hands and donned clean gloves. She then removed the old dressing from the suprapubic catheter and threw it away. Nurse #1 then doffed her gloves and without sanitizing her hands, donned a clean pair of gloves and proceeded to clean the suprapubic area and replaced the dressing with clean gauze and secured with tape. Nurse #1 then doffed her gown and gloves, collected her supplies and trash, wiped down the table and left the resident's room without performing hand hygiene. An observation was made during medication administration on 6/24/26 at 8:15 AM. During the observation Nurse #1 was observed entering the room of Resident #135 with his medications. She did not perform hand hygiene nor did she don gloves before removing Resident #135's straw from his cup and placing it into the cup of water she was providing to be used while taking his medications. Nurse #1 then poured Resident #135's medications into her ungloved hand and Resident #135 took the medications from her hand, one by one, and placed them in his mouth. Nurse #1 then removed Resident #135's straw from the water cup and returned it to the cup in his room. Nurse #1 then returned to the medication cart and pulled Resident #121's medications without performing hand hygiene. She then administered Resident #121's medications and returned to her medication cart without performing hand hygiene. An interview was conducted on 6/25/26 at 2:33 PM with Nurse #1. She revealed she was not aware that she had not sanitized her hands after she had doffed her gloves during catheter care. Nurse #1 also reported that she also was not aware that she did not sanitize her hands after touching the used straw of Resident #135's and assisting him with his medications during medication pass. She also stated she didn't realize she did not perform hand hygiene before providing medications to Resident #121. Nurse #1 stated she knew she was supposed to always sanitize her hands when she removed her gloves and before putting on clean gloves. She also reported she was aware she should have performed hand hygiene between residents during her medication pass. Nurse #1 stated she received education on infection prevention several times throughout the year and is unsure why she did not perform hand hygiene during these times. An interview on 6/24/26 at 11:15 AM with the Infection Preventionist (IP) revealed she was not aware of the errors made by Nurse #1 during catheter care or medication pass. She stated her expectation was that Nurse #1 would have sanitized her hands every time she removed her gloves and before putting on clean gloves during catheter care and that she would have sanitized her hands between residents during medication pass. The IP further stated staff received education on infection control annually and multiple times during the year. An interview on 6/25/26 at 5:15 PM with the Director of Nursing (DON) revealed she was not aware of Nurse #1's errors during catheter care or medication pass. The DON stated it was her expectation that all staff follow infection control best practices to prevent the spread of infection. She further stated staff receive education on infection control annually as well as multiple times throughout the year. An interview on 6/25/26 at (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7:30 PM with the Administrator revealed he would expect Nurse #1 to follow the Hand Hygiene policy at all times. The Administrator stated that all staff had been provided education about infection control and hand hygiene frequently.