STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345228	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgewood Living & Rehabilitation Center	1624 Highland Drive Washington, NC 27889

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 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 observations, record reviews, and interviews with staff, pharmacy consultant, pharmacy accounts receivable clerk, and Medical Director, the facility failed to protect the resident's right to be free from misappropriation of controlled medications for 1 of 6 residents reviewed for medications (Resident #22).The findings included:A review of the facility's policy titled Abuse and Neglect Protocol dated 9/24/18 and last revised on 6/13/21 revealed in part Misappropriation of resident property is defined as the deliberated misplacement, exploitation or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.Resident #22 was admitted to the facility on [DATE].A physician ordered dated 9/25/24 written by the Medical Director read Oxycodone (controlled pain medication used to treat moderate to severe pain) 5mg (milligram tablet). Take one tablet by mouth every 4 hours as needed.A physician ordered dated 9/25/24 written by the Medical Director revealed Buspirone (a medication used to treat anxiety) 5mg tablets. Give 1 tablet by mouth two times a day for mild neurocognitive disorder. This order was discontinued on 7/1/25.A delivery slip from the pharmacy dated 6/13/25 revealed 30 Oxycodone 5mg tablets were delivered to the facility on 6/13/25.A review of the Medication Administration Record (MAR) dated June 1, 2025-June 30,2025 revealed Nurse #8 was the last to sign off as administering the Oxycodone on 6/19/25 at 10:06 PM. Attempts to reach Nurse # 8 who last signed out the oxycodone were unsuccessful.The facility reported incident dated 6/23/25 revealed the Director of Nursing (DON) and Administrator were notified by Nurse #7 that the back of a controlled narcotic card had been taped. The reporting hall nurse observed that six pills in the card had been replaced with similar looking pills and taped closed. The resident did not miss any doses of the prescribed pain medication. Review of the facility reported investigation dated 6/30/25 and signed by the DON and Administrator read in part the facility did not substantiate abuse and or neglect. A telephone interview was conducted with Nurse #7 on 9/4/25 at 10:00 AM. She revealed Resident #22 called out for a pain pill on 6/22/25, when she went to get Resident #22's oxycodone card she noticed the size and shape of the pill did not look like an oxycodone. Nurse #7 then used her cellphone to look up the pill in the card and it was Buspirone. Nurse #7 then looked at the back of the narcotic card and noticed 7 oxycodone pills had been removed and replaced with Buspirone. There was a small incision in the foil like covering on the back of the card covered up by tape. She then reported what she found to Nurse #5. She went on to say Resident #22 rarely asks for her Oxycodone medication and did not feel Resident #22 experienced pain due to this issue as it was an as needed medication and Resident #22 had plenty. Nurse #7 did say when she began this shift, she and Nurse #10 did complete a narcotic count and neither one of them noticed the pills were different or the tape on the back of the card. Nurse #7 added that typically a nurse would not look at the back of the narcotic card when counting. She did not remember what happened to the Buspirone that was diverted into the oxycodone card. Attempts to reach Nurse #10 who counted the narcotics with Nurse #7 were unsuccessful.An interview with Nurse #5 was conducted on 9/4/25 at 10:30 AM. She stated Nurse #7 called her on her mobile phone and she came to the facility. Nurse #7 told her the oxycodone had been replaced with Buspirone. She revealed Nurses were documenting that Resident #22 often refused her Buspirone, she did not know how many had been replaced. Resident #22 did have more Buspirone available to her in the medication cart. An interview with the DON was held on 9/4/25 at 11:10 AM. She revealed she did not remember who notified her of the incident. After notification she went to the facility and spoke with Nurse #7. Nurse #7 told her the Oxycodone had been replaced with Buspirone and taped closed with medical tape. The DON then reported it to the Administrator. Drug tests were administered to everyone that had worked on that medication cart. The DON also stated she did not feel the resident was ever in pain or had anxiety due to the pills being taken. She said Nurse #5 and herself wasted the 7 Buspirone pills. The DON notified the pharmacy about the missing Oxycodone and wasted Buspirone. A delivery slip from the pharmacy dated 6/28/25 revealed 7 oxycodone 5 mg tablets were delivered on 6/28/25.An interview was held with the Pharmacy Director on 9/4/25 at 11:20 AM. She stated she did not see any notes that the incident had been reported but did see on 6/28/25, 7 oxycodone pills were dispersed to the facility for Resident #22. She could not tell me who requested the pills or paid for them.An interview with the Pharmacy Accounts receivable clerk on 9/4/25 at 11:35 AM revealed on 6/28/25, 7 oxycodone pills were dispersed for Resident #22. Resident #22's insurance was billed and paid for the medication. There were no Buspirone ordered or sent out for Resident #22 in the month of June 2025.An interview with Resident #22 was conducted on 9/4/25 at

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of falls. This was for 1 of 5 residents (Resident #74) reviewed for accidents.Findings included:Resident #74 was admitted to the facility on [DATE].Resident #74's hospital record dated 7/19/25 revealed she was being seen after a fall from bed at the facility. She had a significant scalp laceration which measured 15 centimeters in length. Her laceration was repaired using 7 staples and 9 sutures (stiches). Resident #74's annual MDS assessment dated [DATE] revealed she had one fall with no injury and one fall with injury since her prior MDS assessment.Resident #74's medical record revealed no other falls since her prior MDS assessment dated [DATE].On 09/05/2025 at 8:03 AM an interview with MDS Nurse #1 indicated she coded the falls section of Resident #74's MDS assessment dated [DATE]. She reported on 7/19/25 Resident #74 had one fall with injury. She stated her coding on Resident #74's MDS assessment dated [DATE] that Resident #74 also had one fall with no injury was an error. MDS Nurse #1 stated when she reviewed Resident #74's incident reports prior to coding her 7/25/25 MDS assessment, there was one for a fall dated 7/12/24 directly above the one for her fall with injury on 7/19/25, and she looked at the date wrong. On 9/5/25 at 2:37 PM an interview with the Director of Nursing indicated that resident's MDS assessments should be coded accurately.On 9/5/25 at 2:55 PM an interview with the Administrator indicated MDS assessments should be accurately coded.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, the facility failed to develop an individualized, person-centered comprehensive care plan to include the use of side rails for 1 of 2 residents reviewed for side rails (Resident #5).Findings included: 1.Resident #5 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease stage 5 and generalized muscle weakness. Review of Resident #5's electronic record revealed an assessment titled bed rail/assist device dated 8/24/24 and completed by Nurse #9 that indicated Resident #5 did not need or use side rails. A care plan with the latest review date of 9/9/24 revealed no reference to use of side rails for Resident #5. A quarterly Minimum Data Set Assessment (MDS) dated [DATE] revealed Resident #5 was cognitively intact. The MDS indicated Resident #5 required partial to moderate assistance with bed mobility, substantial/maximal assistance with lying to sitting on the side of the bed and was non-ambulatory. The MDS revealed Resident #5 had no impairment to her upper or lower extremities. The MDS indicated Resident #5's siderails were not used as a restraint. An observation and interview were conducted on 9/3/25 at 3:56 PM. Resident #5 was observed lying in bed with bilateral grab bars in the up position on the bed. Resident #5 indicated she used the grab bars to help her roll over in bed during care. The grab bars were approximately 12 inches x 12 inches square. An interview with MDS Nurse #2 was conducted on 9/3/25 at 4:19 PM. MDS Nurse #2 stated she was responsible for updating care plans with information she received from the nursing assessments or verbal directive given to her by nursing. In an interview with the Director of Nursing (DON) on 9/5/25 at 10:08 AM she stated the MDS Nurse was responsible for updating the care plan to include side rail usage. In an interview with the Administrator on 9/5/25 at 10:10 AM she stated side rail usage should be included in the resident's care plan.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident, staff and physician interviews, the facility failed to provide care in a safe manner when Resident #74 a) rolled out of bed during care sustaining a left front scalp hematoma (an injury with swelling caused by blood pooling under the skin) requiring evaluation in the emergency room and b) rolled out of bed during care sustaining a 15 centimeter scalp laceration (cut) requiring evaluation in the emergency room and wound closure with 9 sutures (stiches) and 7 staples. This was for 1 of 5 residents reviewed for accidents (Resident #74).Findings included:1a. Resident #74 was admitted to the facility on [DATE] with a diagnosis of muscle weakness.Resident #74's physician's orders revealed she was not receiving any anti-coagulant (blood thinning) medication.A nursing progress note for Resident #74 dated 7/12/24 at 12:30 PM written by Nurse #2 revealed he had been called to Resident #74's room. Resident #74 was on the floor with a bump on her head. Resident #74 told Nurse #2 she fell out of bed stating, I just kept rolling. Nurse Aide (NA) #2 reported that while she was providing care to Resident #74, Resident #74 rolled off the bed. Resident #74 was sent to the hospital.On 9/5/25 at 12:29 PM a telephone interview with Nurse #2 indicated he was caring for Resident #74 on 7/12/24 on the 7AM-3PM shift. He stated NA #2 reported to him she had been assisting Resident #74 with her bath that morning, had rolled Resident #74 away from herself when providing the care and Resident #74 kept rolling off her bed. Nurse #2 stated when he entered Resident #74's room, he observed Resident #74 on her back on the floor beside her bed. He reported the bed was elevated about 2 feet off the floor. He indicated Resident #74 had not been complaining of pain but had a knot on the side of her head. He stated Resident #74 had been sent to the hospital for an evaluation. The hospital emergency room record for Resident #74 dated 7/12/24 revealed she was being evaluated after a fall in the facility. She had no open wound. She was complaining of right arm pain and a headache. She had a left frontal scalp hematoma with no fractures or brain bleeding.A Teachable Moment statement dated 7/12/24 signed by NA #2 revealed the issue was Resident #74 rolled off her bed when NA #2 was bathing her. NA #2 was instructed post-incident to roll residents towards herself when providing care or to obtain the assistance of a second person when providing care.NA #2 no longer worked at the facility. She was not available for interview.Resident #74's current comprehensive care plan revealed a focus area for Activities of Daily Living (ADL) care. The goal was for Resident #74 to allow care to be provided through the next review. An intervention dated last revised on 7/12/24 was Resident #74 preferred bed baths and required total assistance of 2 staff for this.Resident #74's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired. She had no behaviors or rejection of care. She had functional limitation in range of motion on one side of her upper extremities, and both sides of her lower extremities. She was dependent to roll left to right in bed and for bathing. Resident #74 had no pain in the last 5 days. She had one fall with injury since her last MDS assessment.In an interview on 9/2/25 at 3:13 PM Resident #74 stated she did recall falling once and hurting her left side. She reported she did not recall what happened. She indicated that she felt safe during care.On 9/5/25 at 9:06 AM in an interview the Director of Nursing stated she did not recall much about Resident #74's fall on 7/12/24. She reported she did recall doing some audits and updating resident's care guides.On 9/5/25 at 11:14 AM in an interview the Administrator stated she participated in the investigation and the corrective action plan for Resident #74's fall from bed on 7/12/24. She reported NA #2 had rolled Resident #74 away from herself instead of towards herself and turned to grab a towel. She stated Resident #74 slid off the side of the bed. The Administrator reported at the time of the incident on 7/12/24 Resident #74's assessed level of bed mobility was one person dependent assistance. She stated this was updated to 2 person dependent assistance after the incident. She went on to say Resident #74 should not have experienced a fall during the provision of care.On 9/5/25 at 12:17 PM a telephone interview with the Medical Director indicated Resident #74 should not have experienced a fall during the provision of care.The facility provided the following corrective action plan:Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.On 07/12/2024, during Activities of Daily Living (ADLs) care, Nursing Assistant (NA) #2 turned the Resident #74 away from her; when NA #2 turned to grab a towel, the resident slid off the side of the bed.On 07/12/2024 Nurse #2 assessed the resident post-fall; edema to the forehead was noted. Nurse #3 notified the physician, obtained an order for Emergency Department (ED) evaluation, and the resident was sent to the ED. The Responsible Party (RP) was notified by nursing staff. The Director of Nursing (DON)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff and Medical Director interviews, the facility failed to maintain the sterility of tracheostomy (a surgically created opening in the windpipe through the neck to provide an airway for breathing) care when Nurse #4 failed to perform hand hygiene and don (put on) sterile gloves after touching and disposing of a soiled split gauze pad and inner cannula and before placing the new sterile inner cannula and clean split gauze as well as donning sterile gloves over soiled gloves prior to suctioning. This was for 1 of 1 resident reviewed for tracheostomy care (Resident #9). Findings included: Resident #9 was admitted to the facility on [DATE] with diagnoses that included persistive vegetative state and tracheostomy status. Resident #9's care plan last revised on 7/12/24 revealed him to have a tracheostomy. Resident #9's Annual Minimum Data Set (MDS) assessment dated [DATE] revealed he was unable to be assessed for cognition due to comatose state. He was documented to receive tracheostomy care in the facility. A continuous observation of tracheostomy care was observed on 9/3/25 at 11:53 AM with Nurse #4. At 11:53 AM she performed hand hygiene and donned clean gloves retrieved from her pocket. She poured normal saline onto clean gauze. Nurse #4 then removed the trach cap (sits on the end of the inner cannula) and soiled gauze from behind the tracheostomy flange, picked up clean gauze soaked with normal saline and cleaned around the stoma site behind the tracheostomy flange. Nurse #4 proceeded to change the tracheostomy tie that holds the flange in place and replaced the split gauze that sits behind the flange with a clean split gauze. Next, Nurse #4 removed the soiled inner cannula and inserted the sterile inner cannula. Nurse #4 then removed her gloves and washed her hands to prepare to suction Resident #9. Nurse #4 donned clean gloves taken from her pocket, opened a new container of normal saline, dated the bottle and poured some into a sterile cup. She then put the main suction tube under the resident's blanket at his chest and donned sterile gloves over the gloves she was already wearing. Nurse #4 then opened the sterile suction tubing, attached it to the main tubing that had been under the blanket and suctioned the resident. When finished, Nurse #4 removed both pairs of gloves, threw away the trash and washed her hands. In an interview with Nurse #4 on 9/3/25 at 12:18 PM she stated she should have removed the cap, soiled inner cannula and soiled split gauze, performed hand hygiene, donned sterile gloves and then handled the sterile inner cannula and clean split gauze. In an interview with the Director of Nursing (DON) on 9/3/25 at 12:25 PM, she stated Nurse #4 should have performed all tasks involving soiled items such as removing the used split gauze and used inner cannula and performed hand hygiene and donned sterile gloves before touching the sterile inner cannula and placing the clean gauze behind the flange. The DON indicated Nurse #4 should have removed her soiled gloves, performed hand hygiene and then donned sterile gloves before suctioning. An interview was conducted with the Administrator on 9/3/25 at 2:05 PM. She indicated Nurse #4 should not have touched the sterile inner cannula and clean gauze without performing hand hygiene and donning sterile gloves first. She stated bacteria could have been transferred from the soiled gloves to the sterile cannula and then to Resident #9's respiratory system potentially causing a respiratory infection. She further stated putting sterile gloves over soiled gloves was not acceptable. In an interview with the Infection Preventionist (IP) on 9/5/25 at 9:17 AM she stated that Nurse #4 should have removed the soiled gauze and soiled inner cannula, discarded them, performed hand hygiene and then donned sterile gloves before handling the sterile inner cannula and clean split gauze. The IP indicated keeping the procedure as sterile as possible was important to prevent the spread of bacteria to Resident #9's respiratory system. In an interview with the Medical Director on 9/5/25 at 8:05 AM he stated the respiratory tract was not a sterile space and he did not feel Nurse #4 put Resident #9 at risk by not following professional standards of practice and infection prevention measures.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. (continued on next page)

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F 0700 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 observations, staff interviews, and record review the facility failed to attempt alternatives prior to installing siderails, complete siderail assessments, assess entrapment risk, review the risks and benefits of siderails with the resident /resident representative and obtain informed consent prior to siderail use for 2 of 2 residents reviewed for siderails (Resident #5, Resident #4).Findings included: 1. Resident #5 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease stage 5 and generalized muscle weakness. Review of Resident #5's information face sheet revealed she was her own Responsible Party. Review of Resident #5's electronic medical record revealed an assessment titled bed rail/assist device dated 8/24/24 and completed by Nurse #9. The response to the question, Bed rails/assist devices are indicated for the resident at this time? was no. In an interview with Nurse #9 on 9/5/25 at 10:29 AM he stated he completed the assessment in Resident #5's room on 8/24/24. Nurse #9 indicated the grab bars were on the bed when he completed Resident #5's bed rail/device assessment. Nurse #9 further stated he was unaware grab bars were considered side rails. He did not try alternatives to grab bars, did not assess for entrapment risk or review risks and benefits or obtain consent for grab bars from Resident #5. A care plan with the latest review date of 9/9/24 revealed no reference to use of grab bars for Resident #5. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was cognitively intact. The MDS indicated Resident #5 required partial to moderate assistance with bed mobility, substantial/maximal assistance with lying to sitting on the side of the bed and was non-ambulatory. The MDS further revealed Resident #5 had no impairment to her upper or lower extremities. The MDS indicated Resident #5's grab bars were not used as a restraint. An observation and interview were conducted on 9/3/25 at 3:56 PM. Resident #5 was observed lying in bed with bilateral grab bars in the up position on the bed. Resident #5 indicated she used the grab bars to help her roll over in bed during care. The grab bars were approximately 12 inches x 12 inches square. In an interview with Nurse Aide (NA) #3 on 9/3/25 at 4:01 PM she indicated Resident #5 utilized the bilateral grab bars to assist with turning and repositioning. In an interview with the Unit Manager (UM) #1 on 9/3/25 at 4:15 PM, she indicated the admitting nurse completed the initial bed rail/assist device assessment and MDS completes a new one after that if needed. UM #1 stated they did not try alternatives before using side rails/grab bars and the assessment for entrapment was included in the bed rail/assist device assessment. UM #1 further stated the bed rail/assist device assessment had a place at the bottom for the nurse to sign that they reviewed the risks and benefits of grab bar usage with the resident or the resident representative. UM #1 revealed grab bars are kept on the beds between admissions but are strapped down with zip ties until it was determined if the resident needed them or not. UM #1 was unaware that Resident #5 had bilateral grab bars on her bed. A follow-up observation was conducted on 9/4/25 at 2:49 PM. Resident #5 was lying in bed with both grab bars raised. In an interview with the Director of Nursing (DON) on 9/5/25 at 10:08 AM she stated the admissions nurse completed the first bed rail/assist device assessment and MDS completed one quarterly and as needed, such as if therapy recommends grab bars or the resident or resident representative requests grab bars. The DON further stated entrapment risk was included in the bed rail assessment and the nurse reviews risks and benefits with the resident on the resident's family on a separate paper consent form. The DON indicated she was unaware that alternatives to grab bars needed to be tried and documented before using them and was also unaware that Resident #5 had bilateral grab bars on her bed. The DON revealed grab bars were left on the beds between admissions, but they are supposed to be zip tied down until it was decided if the resident needed them or not. An observation was conducted with the DON on 9/5/25 at 12:14 PM to locate the form that reviewed risks and benefits and gained consent for grab bars in the hard chart. The DON was unable to locate a consent form for the use of grab bars. In an interview with the Administrator on 9/5/25 at 10:10 AM she stated she was unaware alternatives to grab bars needed to be tried before they were used and was unaware grab bars were considered side rails. The Administrator indicated the paper consent form that reviews risks and benefits was probably kept in the hard charts behind the nurse's station. 2. Resident #4 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus Type II and generalized muscle weakness. Review of Resident #4's care plan last revised 7/11/24 revealed an intervention of a right sided grab bar x 1 (side rail)/assist device to allow increased mobility, aid in repositioning and/or transfers. A review of Resident #4's electronic record revealed an assessment titled bed rail/assist device dated 6/23/25 and completed by Nurse #6 indicated Resident #4

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, staff and Medical Director interviews, the facility failed to follow their infection control practices and procedures for Enhanced Barrier Precautions (EBP) during high contact care for a resident with a tracheostomy (a surgically created opening in the windpipe through the neck to provide an airway for breathing) when Nurse #4 provided tracheostomy care without wearing a gown. This was for 1 of 12 staff observed for infection control practices (Nurse #4).Findings included: The facility policy titled Enhanced Barrier Precautions (EBP) dated 4/24/24 stated in part: EBP's are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. Gloves and gowns are applied prior to performing high-contact resident care activities such as tracheostomy care. Observation of Resident #9's door on 9/3/25 at 11:53 AM revealed signage for EBP. The signage indicated that staff providing high contact care to Resident #9 were required to wear gowns and gloves. Further observation revealed a caddy hanging Resident #9's door that contained Personal Protective Equipment (PPE) including gowns and gloves. A continuous observation of tracheostomy care was observed on 9/3/25 at 11:53 AM with Nurse #4. At 11:53 AM she performed hand hygiene and donned clean gloves retrieved from her pocket. Nurse #4 did not don a gown. She proceeded to provide tracheostomy care and suctioning to the resident. In an interview with Nurse #4 on 9/3/25 at 12:18 PM she stated she never wore a gown while performing tracheostomy care as she thought EBP was only needed for incontinence care. Nurse #4 was observed reading the EBP sign located on Resident #9's door after which she stated she saw that she should have been wearing a gown while performing tracheostomy care. In an interview with the Infection Preventionist (IP) on 9/5/25 at 9:17 AM she stated that Nurse #4 should have worn a gown while providing tracheostomy care. The IP indicated following EBP policy was important to prevent the spread of bacteria to Resident #9's respiratory system. In an interview with the Director of Nursing (DON) on 9/3/25 at 12:25 PM, she stated Nurse #4 should have worn a gown and gloves while providing tracheostomy care to prevent the spread of infection from one resident to another. An interview was conducted with the Administrator on 9/3/25 at 2:05 PM. She indicated Nurse #4 should have followed the EBP policy and donned a gown in addition to the gloves before entering Resident #9's room to provide tracheostomy care. In an interview with the Medical Director on 9/5/25 at 8:05 AM he stated the respiratory tract was not a sterile space and he did not feel Nurse #4 put Resident #9 at risk by not following the EBP policy.

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	345228	A. Building B. Wing	09/05/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. (continued on next page)

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F 0883 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 resident, Responsible Party (RP), staff and physician interview the facility failed to provide education regarding the benefits and possible side effects of a pneumococcal immunization, offer a pneumococcal immunization, and then document either a refusal or the administration of a pneumococcal immunization for 1 of 5 residents reviewed for immunizations (Resident #6).Findings included:The facility's undated policy titled Pneumococcal Vaccine revealed in part: All residents will be offered pneumococcal vaccines to aid in the preventing pneumonia/pneumococcal infections.7. Administration of the pneumococcal vaccines or vaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of vaccination.The CDC document titled Summary of Risk-based Pneumococcal Vaccine Recommendations dated 5/24/2025 revealed in part the following: Adults aged 19-[AGE] years old; The following guidance applies to adults younger than [AGE] years old who have a risk condition [risk conditions listed included chronic lung disease including chronic obstructive pulmonary disease (COPD) and cigarette smoking]. Never received any pneumococcal vaccine; give one dose of PCV 15 (Pneumococcal 15-valent Conjugate Vaccine), PCV 20 (Pneumococcal 20-valent Conjugate Vaccine) or PCV 21 (Pneumococcal 21-valent Conjugate Vaccine).Resident #6 was admitted to the facility on [DATE] with a diagnosis of COPD.Resident #6's annual Minimum Data Set (MDS) assessment dated [DATE] revealed she was [AGE] years old. She was moderately cognitively impaired. She was a current tobacco user. Her pneumococcal vaccine was not up to date.Resident #6's current comprehensive care plan revealed she was a supervised smoker.Resident #6's medical record did not reveal any documentation she had been educated on the benefits and possible side effects of a pneumococcal vaccine or refused the vaccine. Additionally, there was no documentation indicating a pneumococcal vaccine had ever been administered to her.On 9/4/25 at 9:29 AM a telephone interview with Resident #6's RP indicated he was not aware of Resident #6 ever having a pneumococcal vaccine. He stated he did not recall the facility ever providing him with education on the risks versus the benefits of the pneumococcal vaccine or offering a pneumococcal vaccine for Resident #6. He reported if the vaccine had been offered, he would have accepted it.On 9/4/25 at 10:39 AM an interview with Resident #6 indicated she did not recall ever receiving a pneumococcal vaccine. She stated if one was offered to her, she would want to have it.On 9/4/25 at 12:15 PM an interview with the facility's Infection Preventionist (IP) indicated she was aware there was an issue with some residents not being up to date with their pneumococcal vaccine. She stated she was trying to get it under control. She reported she had spoken to the pharmacy about some residents who had one step of pneumonia vaccine and had been instructed just to go ahead and use the PCV 20 because that would cover anyone. She reported she had started the process of getting residents up to date beginning with the new admissions because they were the easiest due to already having their consents with education. From there she was taking it chart by chart and was also using a report that showed her everyone's immunizations. She indicated she had not gotten to Resident #6 yet. The IP stated the process should include documentation of education on the risks versus the benefits of the vaccine, consent or refusal and if there was consent then documentation of administration of the vaccine.On 9/4/25 at 1:11 PM an interview with the Director of Nursing indicated she did not have any documentation Resident #6 had been educated on the benefits and possible side effects of a pneumococcal vaccine and refused the vaccine. She reported there was no documentation indicating a pneumococcal vaccine had ever been administered to Resident #6.In an interview on 9/5/25 at 7:51 AM the Medical Director stated that Resident #6's COPD was not oxygen dependent or really a significant risk factor. He reported it was a diagnosis she had, and she probably should have been offered a pneumococcal vaccine.On 9/5/25 at 2:55 PM an interview with the Administrator indicated there should be documentation Resident #6 had been educated on the benefits and possible side effects of a pneumococcal vaccine and refused the vaccine or documentation indicating a pneumococcal vaccine had been administered to her. She reported she thought because of Resident #6's age, this might have gotten missed.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. (continued on next page)

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F 0887 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 record review and resident, staff and physician interviews the facility 1) failed to provide education regarding the benefits and possible side effects of a COVID-19 vaccination, offer a COVID-19 vaccination, and then document either a refusal or the administration of a COVID-19 vaccination in the past 14 months in the resident's medical record for 2 of 5 residents (Resident #54 and Resident #71) and 2) failed to maintain documentation that staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine and were offered the COVID-19 vaccine or information on obtaining a COVID-19 vaccine in the past 14 months for 156 of 156 facility staff reviewed for COVID-19 immunization.Findings included:A review of the facility's policy titled COVID-19 Vaccine dated 12/28/21 revealed in part the following: COVID-19 Vaccine Education for Staff and Resident 1. COVID-19 vaccinations shall be offered to all staff and residents (or applicable POA [Power of Attorney]/Guardian) . per CDC [Centers for Disease Control and Prevention] guidance . 2. All staff and residents (applicable POA/Guardian) shall receive education regarding COVID-19 vaccine in a manner they can understand including information on the benefits and risk consistent with the CDC and/or FDA [Food and Drug Administration] information. The education, at a minimum shall include the FDA, EUA [Emergency Use Authorization] Fact Sheet or VIS [Vaccine Information Statement] for the vaccine being offered.A review of the CDC document titled Staying Up to Date with COVID-19 Vaccines dated 6/6/25 revealed in part the following: CDC recommends a 2024-2025 COVID-19 vaccine for most adults ages 18 and older.The COVID-19 vaccine helps protect you from severe illness, hospitalization, and death. Vaccine protection decreases over time.Getting the 2024-2025 COVID-19 vaccine is especially important if you: never received a COVID-19 vaccine, are ages 65 years and older.are living in a long-term care facility.1a. Resident #54 was admitted to the facility on [DATE] with a diagnosis of depression.Her quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was [AGE] years old. She was cognitively intact. Her COVID-19 vaccine was not up to date.Resident #54's medical record did not reveal any documentation indicating she had been provided education regarding the benefits and possible side effects of a COVID-19 vaccination, offered a COVID-19 vaccination or a refusal or the administration of a COVID-19 vaccination in the past 14 months.On 9/4/25 at 12:42 PM an interview with Resident #54 indicated she thought she recalled being offered a COVID-19 vaccine in the facility after being educated on the risks versus the benefits of the vaccine recently, and she gave her consent. She stated she had not received the vaccine yet but thought she might in the next month or two.b. Resident #71 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD).Resident #71's annual MDS assessment dated [DATE] revealed she was [AGE] years old. She was cognitively intact. Her COVID-19 vaccine was not up to date.Resident #71"s medical record did not reveal any documentation indicating she had been provided education regarding the benefits and possible side effects of a COVID-19 vaccination, offered a COVID-19 vaccination or documentation of either a refusal or the administration of a COVID-19 vaccination in the past 14 months.On 9/4/25 at 10:25 AM an interview with Resident #54 indicated she thought she recalled being offered a COVID-19 vaccine in the facility in the last year. She stated she recalled she refused, because the last 2 times she received a COVID-19 vaccine she got sick with COVID-19.On 9/4/25 at 12:51 PM an interview with the Infection Preventionist indicated she was not sure what the current CDC recommendation was for the COVID-19 vaccine. She stated she was not aware of any education or offer of the COVID-19 vaccine since the last round of boosters for residents which was in October of 2024. She reported the facility did have access to the COVID-19 vaccine and could get it from the pharmacy.In an interview on 9/4/25 at 1:11 PM the Director of Nursing (DON) stated the facility had access to the COVID-19 vaccine and had provided this to some residents in October of 2024. She indicated Resident #54, and Resident #71 should have documentation of education regarding the benefits and possible side effects of a COVID-19 vaccination, an offer of a COVID-19 vaccination, and then documentation of either a refusal or the administration of a COVID-19 vaccine in the past 14 months in their medical record.In an interview on 9/4/25 at 1:13 PM the facility's Regional Director of Clinical Operations stated the COVID-19 vaccine should be offered annually.On 9/4/25 at 2:44 PM an interview with the Administrator indicated she was not sure what the current CDC recommendation was for the COVID-19 vaccine but she though it was recommended annually. She reported there should be documentation in resident's medical record that they received education regarding the benefits and possible side effects of a COVID-19 vaccination, an offer a COVID-19

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F 0925 Level of Harm - Potential for minimal harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on record review, observations, staff and pest control contractor interviews, the facility failed to maintain an effective pest control program to prevent brown crawling bugs in 1 of 1 laundry room. The findings included:A review of the Pest Control Service Agreement dated 4/16/25 revealed the company would provide pest control services monthly and every week on 2 out of the 4 halls. An observation was conducted of the facility laundry room on 9/5/25 at 8:40 AM. The area in which the 2 washing machines were located revealed water standing on the floor covered by a flattened cardboard box. There were also 2 brown crawling bugs on the laundry room wall between the laundry chute and the laundry bin that receives soiled laundry. The observation also revealed 3 brown crawling bugs on the floor near the washing machines.An interview with the Housekeeping and Laundry Director was held on 9/5/25 at 8:50 AM. She stated the flattened cardboard box covering the standing water on the floor draining from the washing machines was to prevent the staff from slipping. She also stated she sees pests often and reports it to the maintenance department. She also enters the requests into the electronic maintenance tracking system. She went on to say she thought pest control representative came every other Tuesday.An interview with the Maintenance Director on 9/5/25 at 9:30 AM revealed he was aware there were pests in the laundry room, both water bugs and roaches. He stated the pest control representative started coming every week in June 2025. He stated when someone reports a pest sighting to him, he notes it in a log and enters it into the electronic maintenance tracking system. He went on to say the common areas are treated weekly and thought the laundry room was part of the common areas.Review of the pest control logbook dated June 2025-August 2025 revealed no pest control service requests were logged for the laundry area.An interview was conducted with the pest control service representative on 9/5/25 at 10:00 AM, he revealed he went to the facility on a weekly basis and treated the halls, he treated the laundry area monthly. He did not have documentation to show what areas he treats. He went on to say the water draining from the washing machines onto the floor was sometimes covered with flattened cardboard, these items could harbor pests and encourage pest growth.An interview was conducted with the Administrator on 9/5/25 at 1:00 PM. She stated the Assistant Maintenance Director shadows the pest control person when they were onsite. She went on to say her expectation was that the laundry room be treated by pest control services every week.An interview with the Assistant Maintenance Director was held on 9/5/25 at 1:30 PM. He stated the pest control service comes every Monday. There were no records of which areas were treated. He added, pest control services had not treated the laundry room, only the laundry chute that carries the soiled linen from the 4th floor hallway down into the basement laundry room. He stated he goes to the laundry area a couple times a week and had not seen pests. He went on to say the standing water covered with flattened cardboard could cause the growth of pests.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and staff interviews the facility failed to ensure nurse aides (NAs) received 12 hours of in-service training annually which included abuse and dementia training. This was for 3 of 5 NA files reviewed (NA#5, NA #6, and NA #7).Findings included: 1a. A review of the employee file and training information for NA #5 indicated a hire date of 2/1/24. There was no dated training to provide evidence NA #2 received 12 hours of in-service training including abuse and dementia training in the previous 12 months.b. A review of the employee file and training information for NA #6 indicated a hire date of 7/11/24. There was no dated training to provide evidence NA #6 received in-service training on abuse and dementia training in the previous 12 months.c. A review of employee file and training information for NA #7 indicated a hire date of 6/20/24. There was no dated training to provide evidence NA #7 received abuse training in the previous 12 months.On 09/5/2025 at 1:06 PM an interview with the Staff Development Coordinator (SDC) indicated she was responsible for tracking NAs in-service training. She reported all training for NAs was done in person. She stated she was not aware that 12 hours of in-service training annually to include abuse and dementia training was mandatory for NAs.On 9/5/25 at 2:45 PM an interview with the Director of Nursing indicated she was not aware NAs needed to have 12 hours of in-service education annually that included abuse and dementia training.In an interview on 09/05/2025 at 2:55 PM the Administrator stated that she knew the facility was lacking in the required education for NAs. She reported that the facility had some turnover in the SDC position, and now hopefully would get back on track with this.