STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365883	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Augustine Manor	7801 Detroit Ave Cleveland, OH 44102

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 record review, review of the Emergency Medical Service (EMS) Patient Care Report, review of hospital records, review of information from the National Institute of Health, review of information from the Centers for Disease Control, facility policy and interview, the facility failed to ensure Resident #195's vision/eye needs were comprehensively assessed, treated, and monitored to timely identify an acute change in condition and prevent a complication requiring hospitalization. This affected one resident (#195) of three residents reviewed for a change of condition. The facility census was 194.Actual harm occurred on 02/15/26 when Resident #195 was transferred to the hospital due to increased pain to her left eye, purulent drainage and loss of vision. The resident was diagnosed with a corneal ulcer and infection resulting in enucleation (surgical removal of the resident's eye). Prior to the hospitalization, on 02/11/26 Resident #195 was diagnosed by the nurse practitioner to have conjunctivitis. However, between 02/12/26 and 02/14/26 there was no evidence the resident's eye was comprehensively assessed/monitored. On 02/14/26 the resident had left eye redness, her eyelid was matted shut, and her left eye had copious amounts of yellow purulent drainage. Staff identified a contact lens in the left eye that the licensed nurse was unable to remove. An order was received to transfer the resident to the hospital at that time; however, prior to the transfer the contact was removed (discrepancy in facility information as to who actually removed the contact). No assessment by a licensed nurse was completed following the removal of the contact on 02/14/26. Findings include: Review of Resident #195's closed medical record revealed an admission date of 09/23/25 with diagnoses including history of transient ischemic attack (TIA) and cerebral infarction without residual deficits, other incomplete lesion at C2 level of cervical spinal cord, systemic lupus erythematosus, major depressive disorder and type two diabetes mellitus with diabetic neuropathy. Resident #195 was transferred to the facility on [DATE] and did not return to the facility. Review of Resident #195's care plan dated 09/23/25 included Resident #195 had limited physical mobility related to weakness, debility, and used a motorized wheelchair. Resident #195 had a history of a C2 lesion with tetraplegia. The goal included for Resident #195 to remain free of complications related to immobility. Interventions included to provide supportive care and assistance with mobility as needed and document assistance as needed.Review of Resident #195's care plan dated 09/23/25 through 02/15/26 did not reveal evidence Resident #195 had a care plan related to vision or the use of/need for visual appliances.Review of Resident #195's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact. The assessment revealed Resident #195 had the ability to see in adequate light and she denied having corrective lenses including glasses or contacts.Review of the CMS (Centers for Medicare and Medicaid Services) RAI version 3.0 Manual Section B for hearing, speech, and vision dated 10/2025 included for planning of care, residents with eyeglasses or other visual appliances should be assisted in accessing them. Use and maintenance should be included in care planning.Review of Resident #195's medical record revealed the facility did not identify the resident used readers to assist with vision.An eye care chart note written by Eye Care Physician #923 dated 12/24/25 included under history of present illness that patient wears cls (contact lenses). The note included Resident #195 had new bifocals (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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	ordered pending insurance approval. There were no additional notes regarding Resident #195's contact lenses).Review of Resident #195's quarterly Minimum Data Set assessment dated [DATE] revealed Resident #195 remained cognitively intact. The assessment revealed Resident #195 required (staff) set up and clean-up assistance with eating and oral hygiene and substantial to maximal (staff) assistance with personal hygiene. Resident #195 used a motorized wheelchair and required set up or clean-up assistance once seated in the wheelchair for the ability to wheel 50 feet and make two turns. This assessment included Resident #195 had the ability to see in adequate light and used corrective lenses including contacts, glasses, or magnifying glass.Record review revealed following the 01/26/26 assessment the Resident #195's care plan was not updated to include a visual deficit, interventions for vision, or the use of any type of visual appliance(s) including corrective lenses, contact lenses, glasses/bifocal glasses or magnifying glass.Review of Resident #195's nursing progress notes and assessments dated 01/26/26 through 02/11/26 did not reveal evidence Resident #195 had irritation, redness, pain or drainage in her left eye. Review of a progress note dated 02/11/26 at 4:27 P.M. authored by Nurse Practitioner (NP) #921 revealed Resident #195 developed left eye drainage and redness with no vision loss or eye pain. The note failed to specify when these symptoms were first identified or include any input from the resident about the condition of her eye or symptom development. The note included Resident #195 had conjunctivitis and was ordered Polymixin (antibiotic eye drops) for seven days.Review of Resident #195's nursing progress notes dated 02/11/26 at 4:27 P.M. through 02/14/26 at 7:17 A.M. did not reveal written evidence of Resident #195's left eye being assessed/monitored during this time period. Review of Resident #195's Medication Administration Record (MAR) dated 02/11/26 at 7:46 P.M. revealed Resident #195 was administered hydrocodone-acetaminophen oral tablet 5-325 mg for a pain level of 7 on a pain scale of zero being no pain and ten being the worst pain. (note: the EMAR notes stated it was given for pain but did not specify where the pain was). Review of Resident #195's MAR dated 02/13/26 at 1:05 A.M. revealed she was given hydrocodone-acetaminophen oral tablet 5-325 mg for a pain level of 6. (note: the EMAR notes stated the medication was given for pain but did not specify the location).Review of a progress note dated 02/14/26 at 7:17 A.M. written by Registered Nurse (RN) #709 included Resident #195 was assessed and noted to have left eye redness, her eyelid was matted shut and her left eye had copious amounts of yellow purulent drainage throughout the shift. The note included a contact lens was observed in the left eye and was unable to be removed despite multiple attempts with sterile saline irrigation. Warm compresses were applied for comfort without improvement. Resident #195 had redness around the left eye and the left cheek. The note included NP #920 was able to visualize (however, an interview with this NP conducted by the surveyor revealed the NP stated she was unable to visualize the contact) and a new order to send Resident #195 to the emergency department (ED) was received. The note then included before the order was carried out the day turn aide came in and was able to remove the contact lens and Resident #195 stated she did not want to go to the ED. NP #920 was notified and gave orders to continue treatment as ordered for conjunctivitis. The note failed to contain any additional information as to how the contact lens was removed, written evidence a licensed nurse completed an assessment of the resident's left eye after the aide removed the contact lens or that any education was provided to the resident related to the NP's order for the resident to be sent to the ED when the resident indicated she did not want to go to the ED. Review of Resident #195's nursing progress notes dated 02/14/26 at 7:17 A.M. through 02/15/26 at 1:05 A.M. revealed no written evidence the resident's left eye was assessed/monitored. Review of Resident #195's progress note dated 02/15/26 at 1:05 A.M. written by Licensed Practical Nurse (LPN) #713 included Resident #195 complained of increased pain in her left eye with pain rated a four out of 10. Record review revealed no written evidence of a comprehensive assessment being completed at this time or of the NP or physician being notified of the increased pain. Review of Resident #195's MAR dated 02/15/26 at 1:05 A.M. revealed hydrocodone-acetaminophen oral tablet 5-325 mg was administered for the resident's complaints of pain at this time. Review of Resident #195's progress (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	note dated 02/15/26 at 4:45 A.M. written by LPN #713 revealed Resident #195 continued to have yellow purulent drainage to the left eye. Warm compresses were applied and antibiotic eye drops were administered, with a note to continue to monitor. Record review revealed no evidence of a comprehensive assessment being completed at this time or of the NP or physician being notified of the continued presence of yellow purulent drainage. Review of Resident #195's progress note dated 02/15/26 at 12:07 P.M. written by LPN #320 revealed Resident #195 complained of pain and vision loss in her left eye. Her left eye was noted to be red with yellow drainage. A new order was obtained at this time to send Resident #195 to the ED for evaluation.Review of a Patient Care Report dated 02/15/26 revealed a call was received at 12:07 P.M. and EMS arrived to the resident at 12:20 P.M. Upon arrival the crew found Resident #195 lying in bed and complaining of left eye pain. Per the staff Resident #195 was being treated for pink eye and was now having vision changes and they were worried about permanent damage. Resident #195 was transported to the ED.Review of Resident #195's progress note dated 02/15/26 at 12:20 P.M. and authored by NP #922 revealed on 02/15/26 at 10:56 A.M NP #922 was called for Resident #195's vision loss and severe left eye pain. The note included Resident #195 and her family requested to have her transported to the hospital and she was sent to the ED for evaluation and treatment. Review of Resident #195's progress notes dated 02/15/26 at 12:29 P.M. revealed Resident #195 was transported to the ED. Resident #195's daughter was aware.Review of Resident #195's hospital ED records dated 02/15/26 revealed Resident #195 had vision changes and a corneal ulcer. Resident #195 presented to the ED due to a left corneal ulcer caused by prolonged contact lenses duration for an unknown amount of time. Upon evaluation and collateral from Resident #195's daughter (phone) the note indicated Resident #195 had a contact in her left eye for a prolonged period of time, anywhere from seven to 12 days. On 02/14/26 an aide picked out the contact which irritated the eye. On 02/15/26 Resident #195's eye was erythematous, swollen, had sticky discharge and she could not open her eyelid on her own. The note revealed the resident confirmed she was losing vision in the left eye. Resident #195 stated she wore contact lenses/glasses for years and thought she wore non-daily contacts. On 02/15/26 during the initial exam (completed in the ED) a contact lens was removed from Resident #195's right eye.Review of a Family/Resident Concern Form dated 02/15/26 involving Resident #195 included Family Member (FM) #924 called and complained her mother was in pain for several days. The form included FM #924 was aware NP #921 evaluated Resident #195 in person and ordered Polytrim ophthalmic drops for conjunctivitis. FM #924 was on the phone with Resident #105 on 02/15/26 and heard Licensed Practical Nurse (LPN) #320 tell Resident #195 to stop rubbing her eye, it would make it worse. FM #924 stated something should have been done to alleviate the pain and the facility failed to do the nursing process. FM #924 questioned why NP #921 did not see the contact in Resident #195's eye. Resident #195's assessment and notes were reviewed and there was no evidence Resident #195 had contact lenses. The form included FM #924 had no idea Resident #195 was wearing contact lenses and stated staff did not follow the nursing process. When Resident #195 reported left eye discomfort she was administered pain medication. Review of a late entry progress note dated 02/15/26 at 11:20 P.M. written by NP #920 revealed on 02/14/26 at 6:08 A.M. RN #709 reported Resident #195 had a contact lens stuck in her left eye. RN #709 reported Resident #195 was prescribed antibiotic eye drops for conjunctivitis. Resident #195 was initially having difficulty removing the contact lens; however, the nurse had since successfully removed the contact lens. The plan was to continue the prescribed antibiotic eye drops to the left eye as ordered. The note documented Resident #195 was currently stable. Orders were to continue eye drops as prescribed and notify a clinician of any change in condition. Disposition was to stay at the facility.Review of Resident #195's hospital Ophthalmology Consult Progress note dated 02/17/26 revealed on 02/15/26 Resident #195 had a corneal ulcer of the left eye. Resident #195 reported pain and irritation of the left eye starting one week prior to presentation that gradually worsened until it became unbearable. The note included Resident #195 reported sleeping in contact lenses since 02/11/26 and said she regularly slept in the contact lenses. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	in a contact by herself. However, RN #709 denied ever seeing contact solution or other supplies in Resident #195's room.Interview on 03/26/26 at 2:41 P.M. with the Director of Nursing (DON) revealed Resident #195 had bifocals delivered on 12/31/25. There was no evidence of a vision assessment or care planning related to the resident's vision needs or use of visual appliances at that time or following.Interview on 03/26/26 at 3:05 P.M. with FM #924 revealed Resident #195 was admitted to the facility on [DATE], she did not know Resident #195 had contacts and no one in the family had brought contacts to the facility. FM #324 revealed she did not know when the contacts were put in Resident #195's eye. The FM revealed the resident had not been able to provide any additional information to family about the contact lenses due to her current status and medical care needs associated with her hospitalization.Interview on 03/27/26 at 9:28 A.M. with DON revealed on 02/14/26 she was made aware Resident #195 had a contact in her eye from Unit Manager (UM) #586. The DON revealed she was told everyone kept looking in Resident #195's eye, they could not see anything, then it was able to be visualized and it was swiped out. The DON revealed Certified Nursing Assistant (CNA) #622 was present when the contact came out.Interview on 03/30/26 at 8:41 A.M. with CNA #622 revealed on 02/14/26 she gave Resident #195 a warm cloth to put on her eye, but the CNA denied removing the contact from the resident's eye. CNA #622 stated all she did was sit Resident #195 up and give her a warm cloth for her eye. Resident #195 compressed the warm cloth on her eye, said her eye hurt and wiped her eye for about five to ten minutes and the contact came out on the cloth. CNA #622 revealed she did not know Resident #195 had a contact in her eye or had contacts before this happened. CNA #622 indicated a couple days before Resident #195 was able to get the contact out of her eye her eye was closed and draining but CNA #622 never saw a contact case or contact supplies in Resident #195's room when she cared for her.Interview on 03/30/26 at 9:30 A.M. with Certified Occupational Therapy Assistant (COTA) #550 revealed she was not aware Resident #195 had contacts. During the interview, COTA #550 revealed the resident had mentioned some concerns with eye irritation. However, she did not recall a time frame when Resident #195 complained of eye irritation, but thought it was a few weeks before she left the facility. COTA #550 stated she mentioned the eye irritation to an aide but did not remember which aide she told. COTA #550 indicated Resident #195 told her nursing was aware of her eye irritation. Interview on 03/30/26 at 3:12 P.M. with NP #920 revealed on 02/14/26 she was on-call for the facility and at 6:08 A.M. she saw Resident #195 via a video call. NP #920 indicated she received a page from a nurse that Resident #105 had a contact in her left eye that the nurse was having a hard time removing. NP #920 revealed she could see Resident #195's eye was red, but could not visualize the contact because it was clear and hard to see on the video. NP #920 indicated at 6:12 A.M. she was notified the contact was removed successfully, Resident #195 already had an order for antibiotic eye drops and she told the nurse to monitor Resident #195 for a change of condition.Interview on 03/30/26 at 4:23 P.M. with DON and Assistant Director of Nursing (ADON) #523 revealed one of her responsibilities was monitoring residents visits with Eye Care Physician #923. ADON #523 indicated she read the eye care notes from each visit and if there were orders, the orders would be at the bottom of the notes page, and she would make sure the orders were placed in the system. ADON #523 confirmed Resident #195 had a history of wearing contacts, and it was stated in the eye care notes that she had a history of wearing contact lens. ADON #523 revealed Resident #195 was not wearing contact lenses when she had her visit with Eye Care Physician #923.Interview on 03/31/26 at 1:02 P.M. with Eye Care Physician #923 revealed 12/24/25 was the first and only time he saw Resident #195. Eye Care Physician #923 indicated he couldn't remember the details but Resident #195 must have mentioned she wore contacts (as it was referenced in the note).Interview on 03/31/26 at 1:08 P.M. with Minimum Data Set Nurse (MDS) #317 revealed on 09/30/25 Resident #195's vision was adequate without glasses. MDS #317 stated residents were given a piece of paper with regular size print on it and are asked to read from it. If residents could not see the regular print then larger size print was chosen and if there were any issues the nurse, nurse practitioner or physician would be notified. MDS #317 revealed Resident (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the facility policy the facility failed to ensure Resident #195's urinary tract infection was treated properly with antibiotics per physician orders. This affected one resident (Resident #195) out of three residents reviewed for antibiotic administration. The facility census was 194.Findings include:Review of Resident #195's closed medical record revealed an admission date of 09/23/25 and diagnoses included history of Transient Ischemic Attack (TIA) and cerebral infarction without residual deficits, other incomplete lesion at C2 level of cervical spinal cord, systemic lupus erythematosus, major depressive disorder and type two diabetes mellitus with diabetic neuropathy. Resident #195 was discharged from the facility on 02/15/26.Review of Resident #195's Quarterly Minimum Data Set assessment dated [DATE] revealed Resident #195 was cognitively intact. Resident #195 required set up and clean-up assistance with eating and oral hygiene and substantial to maximal assistance with personal hygiene. Resident #195 used a motorized wheelchair and required set up or clean-up assistance once seated in the wheelchair for the ability to wheel 50 feet and make two turns. Resident #195 had the ability to see in adequate light and used corrective lenses including contacts, glasses, or magnifying glass. Resident #195 was frequently incontinent of bowel and bladder.Review of Resident #195's care plan dated 02/09/26 included Resident #195 had recurrent urinary tract infections (UTI's). Resident #195's urinary tract infection would resolve without complications by the review date. Interventions included to observe, document and report to the physician signs and symptoms of a UTI such as frequency, urgency, dysuria (burning, pain); to give antibiotic therapy, medications as ordered and monitor and document for side effects and effectiveness; to obtain and monitor lab, diagnostic work as ordered and report results to the physician and follow up as indicated.Review of Resident #195's physician orders dated 01/23/26 at 3:40 P.M. revealed orders for nitrofurantoin macrocrystal (Macrobid - antibiotic medication) oral capsule, give 100 mg by mouth every 12 hours for dysuria for seven days for a UTI. Document any adverse effects of the antibiotic in the IDT notes. Check vital Signs with each administration and document if the signs and symptoms were improving; document a yes or no and if no proceed to the IDT note.Review of Resident #195's progress notes dated 01/23/26 at 3:52 P.M. included Resident #195 was complaining of dysuria and frequency. Nurse Practitioner #921 was notified and new orders were received for nitrofurantoin 100 mg two times a day. A urine specimen for urinalysis and culture and sensitivity was ordered and to not start the antibiotic until the urine specimen was collected. The medication (Macrobid) was scheduled to start on 01/24/26 at 6:00 A.M.Review of Resident #195's Medication Administration Record (MAR) revealed nitrofurantoin macrocrystal (Macrobid) 100 mg was scheduled to start on 01/24/26 at 6:00 A.M. but the first dose was not administered until 01/24/26 at 6:00 P.M. Macrobid 100 mg was not administered on 01/25/26 at either 6:00 A.M. or 6:00 P.M. Macrobid 100 mg was administered on 01/26/26 at 6:00 A.M. but was not administered on 01/26/26 at 6:00 P.M. Macrobid 100 mg was administered on 01/27/26, 01/28/26, 01/29/26 and 01/30/26 at 6:00 A.M. and 6:00 P.M. (note: Resident #195 received 10 antibiotic administrations and not the fourteen that were ordered, and the Macrobid was started before the urine culture was obtained).Review of Resident #195's progress notes dated 01/23/26 through 01/30/26 did not reveal evidence Nurse Practitioner (NP) #921 was notified there was a delay sending Resident #195's urine culture to the lab or the Macrobid was administered before the culture was collected and sent to the lab. There was no evidence NP #921 was notified that Resident #195 did not receive the ordered number of Macrobid 100 mg doses and no evidence this was addressed and orders given.Review of Resident #195's progress notes dated 01/24/26 at 3:45 P.M. revealed an attempt was made to collect Resident #195's urine via a bedpan but the urine specimen was discarded due to contamination with stool. There was no evidence NP #921 was notified.Review of Resident #195's progress notes dated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365883	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Augustine Manor	7801 Detroit Ave Cleveland, OH 44102

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/25/26 at 5:03 A.M. revealed Macrobid 100 mg was not administered due to contaminated urine specimen. There was no evidence NP #921 was notified. Review of Resident #195's progress notes dated 01/25/26 at 10:52 P.M. included Resident #195's urine specimen was not obtained due to delayed transportation due to weather. There was no evidence NP #921 was notified.Review of Resident #195's progress notes dated 01/26/26 at 7:30 P.M. revealed the nurse received an order from an unidentified NP to straight cath as needed. Resident #195 had an order for a urinalysis prior to starting antibiotics.Review of Resident #195's lab results for a urine specimen for urinalysis and culture and sensitivity revealed the urine was collected on 01/27/26 at 5:18 A.M. and reported on 01/29/26. Resident #195's urine had greater than 100,000 CFU (Colony Forming Units) per ml of Escherichia Coli and the Escherichia Coli was susceptible to nitrofurantoin (Macrobid).Review of Resident #195's progress notes dated 01/27/26 at 6:10 A.M. revealed Resident #195's urine specimen for urinalysis and culture and sensitivity was obtained via a straight catheter. The urine was yellow and cloudy without a foul odor.Review of a late entry progress note dated 02/03/26 at 6:27 A.M. revealed on 01/28/26 at 6:25 A.M. urine culture was obtained and Resident #195's urine was positive for E.coli. Resident #195 received Macrobid with improvement in her symptoms.Review of Resident #195's progress notes dated 02/11/26 at 4:27 P.M. and written by NP #921 included Resident #195 was treated with a course of Macrobid for a urinary tract infection. Resident #195 stated she continued to get recurrent UTI's and complained of burning with urination again and urinary frequency. Repeat urine specimen for urinalysis and culture and sensitivity.Review of Resident #195's urinalysis results included the urine was collected and reported on 02/12/26 and Resident #195's urine was dense, turbid, had one plus protein, a moderate amount of bacteria, had greater than 25 WBC/HPF (High Power Field), and her leuk esterase was 500 Leu/uL. These results were abnormal.Interview on 04/01/26 at 3:58 P.M. with Assistant Director of Nursing (ADON) #621 confirmed Resident #195's Macrobid was not started on 01/24/26 at 6:00 A.M. as scheduled and indicated the facility had to wait for the Macrobid to be delivered. ADON #621 revealed Resident #195 had a history of recurrent urinary tract infections. ADON #621 indicated on 01/25/26 in the morning the urine specimen was contaminated and could not be sent to the lab and on 01/25/26 in the evening the urine specimen was not picked up due to the weather. ADON #621 revealed the antibiotics were not given because the urine specimen was pending. ADON #621 confirmed Resident #195's Macrobid was administered on 01/24/26 at 6:00 P.M. and on 01/26/26 at 6:00 A.M. and both of the doses were administered before the urine specimen was collected. ADON #621 confirmed Resident #195 did not receive the ordered number of Macrobid 100 mg doses and NP #921 was not notified.Interview on 04/01/26 at 5:00 P.M. with Nurse Practitioner (NP) #921 revealed the nurses knew she was a big [NAME] on urine specimens being obtained before antibiotics were administered because she did not want a skewed culture. NP #921 revealed she was not sure why Resident #195 did not get the full seven days of Macrobid as ordered and she did not recall being called about it. NP #921 indicated she did not know why she was not called about extending the days Resident #195 received the Macrobid because she did not get the full course of antibiotics that were ordered. NP #921 revealed she saw Resident #195 on 01/28/26 and told the nurses to complete the course of Macrobid. NP #921 revealed she could not say one way or the other if not getting the full course of Macrobid ordered on 01/23/26 could be related to Resident #195 recurrent urinary tract infection on 02/12/26. NP #921 indicated the best course of action would have been for the nurses to contact her and inform her Resident #195 did not get the full course of Macrobid and she could make a decision about what to do. Review of the facility policy titled Medication Guide revised 08/2020 included administered medications were consistent with physician's orders including dose, strength, route and frequency.This deficiency represents non-compliance investigated under Complaint Number 2748620.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure enhanced barrier precautions were followed for Resident #65. This affected one resident (#65) of three residents observed for infection control. The facility census was 194.Findings include:Review of Resident #65's medical records revealed an admission date of 06/08/17 with diagnoses including gastrostomy (feeding tube), right sided paraplegia, muscle weakness and dysphagia (difficulty swallowing).Review of Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #65 had impaired cognition. Resident #65 was dependent with toileting, bathing and transfers. Review of care plan dated 03/18/26 revealed Resident #65 required Enhanced Barrier Precautions (EBP) related to device. Interventions included appropriate signage on residents door, and instruct caregivers to wear disposable gowns and gloves during physical contact with resident. Review of current physician orders for March 2026 revealed Resident #65 was ordered EBP due to device every shift.Observation of medication administration on 03/26/26 at 7:56 A.M. for Resident #65 with Licensed Practical Nurse (LPN) #320 revealed signs posted on Resident #65's door that indicated resident was on Enhanced Barrier Precautions (EBP) and Personal Protective Equipment (PPE) was to be worn that included gown and gloves. LPN had prepared Resident #65's medications and had entered Resident #65's room and had proceed to administer medications via Resident #65's feeding tube and had not donned PPE prior to medication administration. Interview with LPN #320 after medication administration revealed Resident #65 was on EBP related to his feeding tube and stated she should have worn PPE prior to administering the medications.Review of facility policy titled Enhanced Barrier Precautions revised 04/2025, revealed an order for EBP will be obtained for residents with indwelling medical devices that include feeding tubes and PPE is necessary when performing high contact care.