

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415059	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/12/2026
NAME OF PROVIDER OR SUPPLIER  Adviniacare Orchard, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  135 Tripps Lane East Providence, RI 02915	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on surveyor observation, record review, and staff interview, the facility failed to ensure the residents' environment remained as free of accident hazards as possible related to the storage and management of biohazardous waste (any material contaminated with infectious agents or potentially infectious substances that pose a risk to health, including blood and body fluids) and sharps (any instruments or devices with sharp points or edges that can puncture or cut skin, posing risks of injury and disease transmission). This failure resulted in unsecured, unlocked, and accessible biohazardous waste and sharps on four (4) of four (4) units observed, including a secured memory care unit, placing residents at risk for exposure to bloodborne pathogens, infectious disease, and physical injury. Findings are as follows: Review of a community-reported complaint submitted to the Rhode Island Department of Health on 1/7/2026 alleged that trash and biohazardous waste were blocking the entire back side/entrance of the facility. Further review of this complaint revealed that biohazardous waste was being stored in unlocked and unsecured rooms. Review of the facility policy dated April 2025 titled Storage of Sharps states in part, To maintain an avoidable accident-free environment, all sharps (scissors, razors, lancets, needles,) are stored and secured in designated areas at all times when not in use. Ensure that all sharps are placed in their designated locked storage containers at all times. Ensure that sharps are contained and stored in a secured manner. Do not allow residents/patients with functional and/or cognitive limitations to handle such objects as they may pose a hazard. 1. During a surveyor observation on 1/8/2026 at 7:48 AM off the back entrance of the facility, a room was observed with the door half open. The room contained multiple boxes labeled Infectious Waste, Biohazard Medical Waste. The boxes were overflowing with sharps containers (containers used for the safe disposal of used needles, syringes, and other sharp medical items to prevent needlestick injuries and the spread of infection), along with red bags labeled Biohazard filled with sharps containers. Additional red biohazard bags filled with sharps containers were observed on the floor extending to the doorway and were visible from outside the room. 2. During a surveyor observation on 1/8/2026 at 8:25 AM, in the presence of the Administrator, the same room was observed with the door half open and contained multiple boxes labeled Infectious Waste overflowing with sharps containers and red biohazard bags filled with sharps containers and other biohazardous waste. During a surveyor interview immediately following the above-mentioned observation with the Administrator, she acknowledged the room was unlocked and contained biohazardous waste. 3. During a surveyor observation of the same room on 1/8/2026 at 8:44 AM, in the presence of the Assistant Maintenance Director, he acknowledged that the room was filled with biohazardous waste and that the door was unlocked. He further indicated that the room was filled because the contracted biohazard waste removal company had not picked up the waste due to non-payment by the facility. 4. During surveyor observations on 1/8/2026, in the presence of the Director of Nursing Services (DNS), biohazardous waste was observed stored in unlocked and unsecured</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>rooms on the following units where residents reside:a. At 9:13 AM, on the [NAME] Unit there was a box overflowing with sharps containers, with five additional sharps containers observed on top of the box. One of the sharps containers was observed open with needles and other sharp objects exposed.b. At 9:16 AM, on the [NAME] Unit there were boxes overflowing with sharps containers, with nine additional sharps containers observed on top of the boxes.c. At 9:24 AM, on the Cortland Unit there were fourteen (14) sharps containers observed on the floor. Additionally, there were multiple Intravenous lines (IV, a flexible tube used to deliver fluids, medications, nutrition, or blood products directly into a patient's bloodstream via the patient's vein) with blood visibly in the lines and the lines were hanging from the sharps' containers.d. At 9:27 AM, on the [NAME] Unit (memory care) there was a box overflowing with sharps containers, with five additional sharps containers observed on top of the box.During a surveyor interview with the DNS on 1/8/2026 at 9:33 AM, she acknowledged that the rooms on the above-mentioned units were unlocked and contained sharps containers and boxes of biohazardous waste. The DNS was unable to provide evidence that the biohazardous waste was stored in secured rooms not accessible to residents and acknowledged that the waste had not been removed from the units. Additionally, the DNS was unable to provide evidence the residents' environment remained as free of accident hazards as possible on the four units observed.During the above observations, multiple residents were observed ambulating and self-propelling in close proximity to the unsecured and unlocked rooms containing biohazardous waste. One of the units observed was a secured memory care unit with residents diagnosed with cognitive impairments.During a surveyor interview on 1/8/2026 at 9:35 AM with a representative from the contracted biohazard waste removal company, stated that services were placed on hold in May of 2025 due to non-payment by the facility and that the last biohazardous waste removal occurred on May 29, 2025.A review of facility records failed to reveal evidence that the facility's contacted biohazard waste removal company or any other licensed biohazardous waste removal company had been at the facility for the removal and disposal of biohazardous waste since May 2025.During an interview with the Administrator on 1/8/2026 at approximately 1:00 PM, she indicated that she was aware of the biohazardous waste disposal issues upon being hired in October 2025 and acknowledged that waste was not disposed of appropriately due to non-payment. The Administrator was unable to provide evidence that the facility ensured the residents' environment remained as free of accident hazards as possible related to the storage of biohazardous materials.As a result of these failures, the facility did not ensure biohazardous waste and sharps were secured, managed, and disposed of in accordance with the facility policy and safety standards, creating a hazardous environment with the potential for serious harm to residents.Cross reference F 880, F 814, and F 837</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>Based on surveyor observation, record review, and staff interview, the facility failed to ensure the proper disposal and management of garbage, resulting in an accumulation of garbage at the back of the facility that obstructed exit routes and posed an immediate hazard to residents' safety. This failure placed residents at risk in the event of an emergency evacuation. The facility was found to be in past noncompliance. Findings are as follows: Record review of a community-reported complaint submitted to the Rhode Island Department of Health on 1/7/2026 alleged that large amounts of trash were blocking the entire back side of the facility. Further review of the complaint revealed that the accumulation of garbage obstructed exit doors, resulting in blocked fire exits for residents to use in the event of an emergency evacuation, posing an extreme risk and immediate hazard to resident safety. Record review of photographs obtained from the complainant, dated 1/7/2026 at 2:13 PM, revealed a significant accumulation of garbage at the back of the facility. The photographs showed multiple black and white trash bags containing garbage, including yellow personal protective gowns. The garbage was observed blocking exit doors at the back entrance shared with the facility's main kitchen and extended the full length of the entrance. The accumulation covered the entire platform surface, extended to the ground below, and obstructed the exit ramp. Multiple large garbage bins filled to capacity with trash bags were also observed. During a surveyor interview on 1/8/2026 at 9:39 AM with a representative from the facility's contracted garbage removal company, the representative indicated that garbage removal services were placed on hold after November 28, 2025 due to non-payment by the facility. The representative confirmed that November 28, 2025, was the last scheduled garbage pickup prior to services resuming on 1/7/2026. The representative further stated that the company was contracted to remove garbage weekly on Thursdays. During a surveyor interview on 1/8/2026 at 10:28 AM with the Assistant Director of Maintenance, he acknowledged that garbage had not been picked up by the contracted garbage removal company from November 2025 until 1/7/2026 due to non-payment by the facility. After reviewing the photographs with the surveyor, he confirmed that the images accurately depicted the accumulation of garbage and waste at the back of the facility blocking exit routes. He further acknowledged that garbage removal was scheduled weekly but had not occurred as scheduled due to non-payment. During a surveyor interview on 1/8/2026 at approximately 1:00 PM, the Administrator acknowledged the photographs depicting the large accumulation of garbage at the back entrance of the facility. She indicated that the garbage was removed by the contracted garbage removal company after the issue was brought to the facility's attention by the complainant on 1/7/2026. During a surveyor observation of the back entrance of the facility on 1/8/2026 at 7:48 AM, no garbage accumulation was observed. Two large blue dumpsters were present and covered, and exit routes were unobstructed. Based on observation, interview, and record review, the facility failed to ensure the timely removal and proper management of garbage, resulting in blocked exit routes and hazardous conditions. As the conditions were corrected prior to the surveyor observations, the facility was determined to be in past noncompliance. Cross reference F 880, F 689, and F 837</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on surveyor observation, record review, and staff interview, the facility's governing body failed to ensure the effective implementation and oversight of policies related to the management and operation of the facility. Specifically, the governing body failed to ensure the proper disposal and management of biohazardous waste and garbage, resulting in unsecured biohazardous waste stored in the facility and an accumulation of garbage at the back of the building that obstructed exit routes and posed an immediate hazard to the residents' safety. Findings are as follows: Review of the Facility assessment dated [DATE], states in part, Resources: The physical environment, services and other physical plant considerations are reviewed to ensure [the facility] meet the needs of our residents, assuring the safety and well-being for each resident. Waste management, hazardous waste management. Review of a community-reported complaint submitted to the Rhode Island Department of Health on 1/7/2026 alleged that large amounts of biohazardous waste were stored in unsecured rooms and that garbage was blocking the entire back side of the facility. Further review revealed that the accumulation of garbage obstructed exit doors, resulting in unavailable fire exits for residents to use in the event of an emergency evacuation, posing an extreme and immediate risk to resident safety. Review of photographs obtained from the complainant dated 1/7/2026 at 2:13 PM revealed a significant accumulation of garbage at the back of the facility. The photographs showed multiple black and white trash bags containing refuse, including yellow personal protective gowns. The garbage was observed blocking exit doors at the back entrance shared with the facility's main kitchen and extended the full length of the entrance. The accumulation covered the entire platform surface, extended to the ground below, and obstructed the exit ramp. Multiple large garbage bins filled to capacity with trash bags were also observed. 1. During a surveyor observation on 1/8/2026 at 7:48 AM off the back entrance of the facility, a room was observed with the door half open. The room contained multiple boxes labeled Infectious Waste, Biohazard Medical Waste overflowing with sharps containers, along with red bags labeled Biohazard. Multiple red biohazard bags filled with sharps containers were observed on the floor extending to the doorway and visible from outside the room. a. During a surveyor observation on 1/8/2026 at 8:25 AM, in the presence of the Administrator, the same room was observed with the door half open and contained multiple boxes labeled Infectious Waste overflowing with sharps containers and red biohazard bags filled with sharps containers and other biohazardous waste. During an interview immediately following the observation, the Administrator acknowledged the room was unlocked and contained biohazardous waste. b. During a surveyor observation on 1/8/2026 at 8:44 AM, in the presence of the Assistant Maintenance Director, he acknowledged that the room was filled with biohazardous waste and that the door was unlocked. He further stated that the contracted biohazard waste removal company had not removed the waste due to non-payment by the facility. 2. During surveyor observations on 1/8/2026, in the presence of the Director of Nursing Services (DNS), biohazardous waste and sharps containers were observed stored in unlocked and unsecured rooms on the following units: a. At 9:13 AM, on the [NAME] Unit there was a box overflowing with sharps containers, with five additional sharps containers observed on top of the box. One sharps container was observed open with needles and other sharp objects exposed. b. At 9:16 AM, on the [NAME] Unit there were boxes overflowing with sharps containers, with nine additional sharps containers observed on top of the boxes. c. At 9:24 AM, on the Cortland Unit there were fourteen (14) sharps containers observed on the floor. Additionally, there were multiple Intravenous lines (IV, a flexible tube used to deliver fluids, medications, nutrition, or</p> <p>(continued on next page)</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>blood products directly into a patient's bloodstream via the patient's vein) with blood visibly in the lines and the lines were hanging from the sharps' containers.d. At 9:27 AM, on the [NAME] Unit (memory care) there was a box overflowing with sharps containers, with five additional sharps containers observed on top of the box.During an interview with the DNS on 1/8/2026 at 9:33 AM, she acknowledged that the rooms on the above-mentioned units were unlocked and contained sharps containers with biohazardous waste. She further stated that the biohazardous waste had not been removed due to non-payment to the waste removal company by the facility owner.During a surveyor interview on 1/8/2026 at 9:35 AM with a representative from the facility's contracted biohazard waste removal company, the representative stated that services were placed on hold in May of 2025 due to non-payment and that the last biohazardous waste removal occurred on May 29, 2025.A review of facility records failed to reveal evidence that the facility contracted biohazard waste removal company, or any other licensed biohazardous waste removal company had been to the facility for removal or disposal of biohazardous waste since May 2025.During a surveyor interview on 1/8/2026 at 9:39 AM with a representative from the facility's contracted garbage removal company, the representative stated that garbage removal services were placed on hold after November 28, 2025, due to non-payment. The representative confirmed that November 28, 2025, was the last scheduled garbage pickup prior to services resuming on 1/7/2026.A review of email communications dated 11/19/2025 and 1/5/2026 between the Administrator and the Regional Director of Operations (governing body) revealed that the Administrator informed the governing body that both the biohazardous waste and garbage removal accounts were on credit hold.During a surveyor interview on 1/8/2026 at 10:28 AM, the Assistant Director of Maintenance acknowledged that garbage was not removed from November 2025 until 1/7/2026 due to non-payment and that biohazardous waste had not been removed due to lack of space, as the designated biohazard room was filled to capacity. He further stated that biohazardous waste had not been removed from the facility since the summer of 2025.During surveyor interviews on 1/8/2026 at 10:30 AM and on 1/9/2026 at 10:49 AM, the Administrator acknowledged that the corporation owning the facility is the governing body and is responsible for authorizing payments for contracted services. She further acknowledged that the governing body was aware that biohazardous waste and garbage removal services were suspended due to non-payment.As a result of the governing body's failure to ensure adequate oversight and provision of essential services, the facility did not maintain safe waste management practices, resulting in hazardous conditions that placed residents at risk for serious harm.cross reference F 689, F 880, and F 814</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on surveyor observation, record review, and staff interview, the facility failed to maintain an effective infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the transmission of communicable diseases and infections. Specifically, the facility failed to properly store, secure, and dispose of biohazardous waste (any material contaminated with infectious agents or potentially infectious substances that pose a risk to others) and overfilled sharps containers (used for the safe disposal of used needles, syringes, and other sharp medical items to prevent needlestick injuries and the spread of infection) in unsecured and unlocked areas on four (4) of four (4) units observed, including a secured memory care unit. These failures placed residents at risk for exposure to bloodborne pathogens, infectious diseases, and physical harm. Findings are as follows:Review of a community-reported complaint submitted to the Rhode Island Department of Health on 1/7/2026 alleged that trash and biohazardous waste were blocking the entire back side of the building. Further review revealed that biohazardous waste was being stored in unlocked and unsecured rooms.Review of the facility's policy dated April 2025 titled Storage of Sharps states in part, .To maintain an avoidable accident-free environment, all sharps (scissors, razors, lancets, needles.) are stored and secured in designated areas at all times when not in use.Ensure that all sharps are placed in their designated locked storage containers at all times.Ensure that sharps are contained and stored in a secured manner.Do not allow residents/patients with functional and/or cognitive limitations to handle such objects as they may pose a hazard.1.During a surveyor observation on 1/8/2026 at 7:48 AM off the back entrance of the facility, a room was observed with the door half open. The room contained multiple boxes labeled Infectious Waste, Biohazard Medical Waste overflowing with sharps containers, along with red bags labeled Biohazard. Multiple red biohazard bags filled with sharps containers were also observed on the floor extending to the doorway and were visible from outside the room.2. During a surveyor observation on 1/8/2026 at 8:25 AM, in the presence of the Administrator, the same room was observed with the door half open and contained multiple boxes labeled Infectious Waste overflowing with sharps containers and red biohazard bags filled with sharps containers and other biohazardous waste. During an interview immediately following the observation, the Administrator acknowledged the room was unlocked and contained biohazardous waste.3. During a surveyor observation on 1/8/2026 at 8:44 AM, in the presence of the Assistant Maintenance Director, he acknowledged the room was filled with biohazardous waste and that the door was unlocked. He further indicated that the contracted biohazard waste removal company had not picked up the waste due to non-payment by the facility.4. During surveyor observations on 1/8/2026, in the presence of the Director of Nursing Services (DNS), biohazardous waste and sharps containers were observed stored in unlocked and unsecured rooms on the following units, where residents reside:a. At 9:13 AM, on the [NAME] Unit there was a box overflowing with sharps containers, with five additional sharps containers observed on top of the box. One sharps container was observed open with needles and other sharp objects exposed.b. At 9:16 AM, on the [NAME] Unit there were boxes were overflowing with sharps containers, with nine additional sharps containers observed on top of the boxes.c. At 9:24 AM, on the Cortland Unit there were fourteen (14) sharps containers observed on the floor. Additionally, there were multiple Intravenous lines (IV, a flexible tube used to deliver fluids, medications, nutrition, or blood products directly into a patient's bloodstream via the patient's vein) with blood visibly in the lines and the lines were hanging from the sharps' containers.d. At 9:27 AM, on the [NAME] Unit (memory care) there was a box overflowing with sharps containers, with five additional sharps containers observed on top of the box.During an interview with</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>the DNS on 1/8/2026 at 9:33 AM, she acknowledged that the rooms on the above-mentioned units were unlocked and contained sharps containers with biohazardous waste. The DNS was unable to provide evidence that the sharps containers were stored in secured areas not accessible to residents to help prevent the transmission of communicable diseases and infections. During the above observations, multiple residents were observed ambulating and self-propelling in close proximity to the unsecured and unlocked rooms containing biohazardous waste. One of the units observed was a secured memory care unit housing residents diagnosed with cognitive impairment. During a surveyor interview on 1/8/2026 at 9:35 AM with a representative from, the facility's contracted biohazard waste removal company, the representative stated that services were placed on hold in May 2025 due to non-payment by the facility and that the last biohazardous waste removal occurred on May 29, 2025. A review of facility records failed to reveal evidence that the facility's contacted biohazard waste removal company or any other licensed biohazardous waste removal company had been at the facility for the removal and disposal of biohazardous waste since May 2025. During an interview with the Administrator on 1/8/2026 at approximately 1:00 PM, she stated that she was aware of the biohazardous waste disposal issues upon being hired in October 2025 and acknowledged that biohazardous waste was not disposed of appropriately due to non-payment. The Administrator was unable to provide evidence that the facility maintained a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections. As a result of these failures, the facility did not implement and maintain an effective infection prevention and control program related to the safe storage and disposal of biohazardous waste and sharps, creating a risk for transmission of infectious diseases and potential serious harm to residents. Cross reference F 689, F 814, and F 837</p>		