STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425414	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Retreat at Wellmore of Daniel Island	580 Robert Daniel Drive Charleston, SC 29492

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 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, manufacturers' recommendations, observations, and interviews, the facility failed to: 1. Ensure that food items were stored, prepared, distributed, and or served in accordance with professional standards of practice in one of one main kitchen and four of four satellite kitchenettes. 2. Ensure that staff adequately monitored and documented the sanitation levels of all facility dishwasher machines. Specifically, on 03/18/26, the facility was made aware of concerns with the main kitchen's dishwasher following a service repair by Ecolab and continued to prepare and serve meals using dishware that was not properly sanitized in five of five dishwashers reviewed.On 04/16/26 at 4:20 PM, the State Agency (SA) determined that the facility's non-compliance with one or more federal health, safety, and/or quality regulations has caused or was likely to cause serious injury, serious harm, serious impairment, or death. On 04/16/26 at 4:20 PM, the survey team provided the Administrator with a copy of the Centers for Medicare and Medicaid Services (CMS) Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 03/18/26. The IJ was related to 42 CFR 483.60 - Food and Nutrition Services. On 04/17/26 at 12:52 PM, the facility provided an acceptable IJ Removal Plan. On 04/17/26 at 1:20 PM, the survey team validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F812 at a lower scope and severity of F.1. Review of the facility policy Food Preparation and Service last revised November 2022 revealed, Food and nutrition employee prepare, distribute, and serve food in a manner that complies with safe food handling practices. Policy interpretation and implementation include: Danger Zone, means temperatures above 41F and below 135F that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. Food Preparation means the series of operational process involving preparing foods for serving. Food distribution means the process involved in getting food to the resident. This may include holding foods on the steam table or under refrigeration or cold temperature control, dispensing food portions for individual residents, family style and ding room service, or delivering meals to residents' rooms. Thawing frozen food procedures include, foods are not thawed at room temperature, appropriate thawing procedures include thawing in the refrigerator in a drip-proof container. Food preparation, cooking, and holding time/temperatures policies include, food thermometer use to check food temperature are clean, sanitized, and calibrated for accuracy. Food distribution and service procedures include; proper hot and cold temperature are maintained during food distribution and service. Foods that are held in the temperature danger zone' are discarded after four hours. The temperature of foods held in steam tables are monitored throughout the meal service by food and nutrition services staff. Food and nutrition services staff wear hair restraints (hair net, beard restraints) so that hair does not contact food. All food service equipment will be sanitized according to current guidelines and manufacturers' recommendations. Review of the facility policy titled Food Receiving and Storage last revised November 2022 revealed, Foods shall be received and stored in a manner that complies with safe food handling practices. Dry Food Storage policies include non-refrigerated foods, disposable dishware and napkins are stored in a (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 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	designated dry storage unit which is temperature and humidity controlled, free of insects and rodents and kept clean. Dry foods that are stored in bins are removed from original packaging, labeled and dated (use by) date, such foods are rotated using a first-in-first-out system. Refrigerated/Frozen Storage procedures include, all foods stored in the refrigerator or freezer are covered, labeled, and dated (use-by) date. Refrigerated foods are stored in a way that promotes adequate air circulation around food storage containers. Refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen, or discarded. Frozen foods are maintained at a temperature to keep the food frozen solid. Wrappers of frozen foods must stay intact until thawing. An initial tour of the Main Kitchen with the Executive Chef (EC) on 04/14/26 from 10:09 AM to 10:26 AM, revealed the following: In the Main Kitchen: Two ovens with an excessive amount of grease buildup. The EC stated that this item is cleaned monthly by dietary staff. 1 bottle of Smucker's Plate Scraper Carmel opened and undated. 1 container of Bay Leaves that was opened and dated 11/15/24, during interview with the EC he stated seasonings should only be kept for six months 1 bag of powdered sugar opened and undated. The Ice Machine with a black substance on the inside of the right panel. In the Walk-In Cooler: 1 9lb container of Glorious Morning Frozen Gourmet Muffin Batter - not dated when opened 1 bag of crumbled feta cheese - not dated when opened 1 box of Celery that was observed to be wilted 1 box of Lettuce that was observed to be wilted and was received by the facility on 03/31/26 1 slab of pork that was observed defrosting, blood was observed actively dripping on the Walk-In Cooler floor, there was no observation of this item in a drip-container/pan. In the Dry Storage Room: 3 bags of granola opened and undated. 1 25 lb. bag of Organic Yellow Split Peas open and undated. 1 bag of Cake Mix opened and undated. Gnats flying around/ lying on top of bottles on vinegar on the bottom shelf. (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Observation of the Walk-In Cooler at 10:26 AM revealed the following: 1 Key Lime Pie opened and undated. 1 bag of crumbled sausage not dated after opening/ not properly sealed to prevent freezer burn. 1 box/bag of cauliflower open and undated and not properly sealed to prevent freezer burn. An observation of the [NAME] Unit Satellite Kitchenette on 04/14/26 at 10:33 AM revealed an excessive amount of build-up of crumbs in the tray storage area. An observation of the [NAME] Unit Satellite Kitchenette on 04/14/26 at 10:37 AM revealed an excessive amount of build-up of crumbs in the tray storage area. An observation of the Folly Unit Satellite Kitchenette on 04/14/26 at 11:50 AM revealed Certified Nursing Assistant (CNA)1 and CNA2 assisting with the distribution of resident meals inside the Kitchenette without a hairnet. During observation CNA2 was observed with a hairnet but was not fully covering approximately 5 inches of her hair. A follow-up observation of the Main Kitchen Dry Storage Room on 04/15/26 at 10:49 AM revealed a second observation of gnats flying around/lying on top of vinegar bottles on the bottom shelf. An observation of the Main Kitchen near the Dishwasher/Drying station on 04/15/26 at 10:51 AM revealed three containers stacked on top of each other preventing drying and/or air flow. During an observation in the Main Kitchen with the EC of the food preparation and service process revealed The EC checking the temperature of baked fish, mixed vegetables and potato fries without using a new sanitizer wipe between each item. The EC then accidentally dropped the digital thermometer and then washed it off in the nearby handwashing sink with hand soap and a sanitizer wipe. The EC was then observed using the digital thermometer to check another container of mixed vegetables in the insulated heated holding cabinet without adequately recalibrating the digital thermometer. During a follow-up observation of the [NAME] Unit Satellite Kitchenette on 04/15/26 at 11:28 AM, of the food preparation and service process, [NAME] (C)1 was observed taking pans of the cooked food from the insulated food cabinet and placing the pans on the countertop without using the steam table to ensure food holding temperatures. During a follow-up observation of the Folly Unit Satellite Kitchenette on 04/15/26 at 11:39 AM, of the food preparation and service process, again revealed C1 plating and serving food without using the steam table to ensure food holding temperatures. The following food items did not meet minimum requirements for holding temperatures: Snap Peas - during initial temperature check was 128F, then had to be reheated in the microwave to 175F Tater Tots - 91F. A second observation of CNA 2 on 04/15/26 at 12:10 PM, again revealed CNA2 wearing a hairnet that (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Review of an Ecolab Report dated 04/16/26 revealed Service requested, sanitizer line was pinched so I cut out the bad ward of the line and got the sanitizer pumping through in the machine. Review of an Ecolab Report dated 04/17/26 revealed Service requested, second call same issue, temperature issue but also pressure issue. Health Inspection is there and needs service today 04/17/26. Services comments, replaced pressure gauage valve and tested everything multiple times to make sure everything working properly. Review of the Main Kitchen Dish Machine Temperature/Sanitation Log for November 2025, January 2026, February 2026, March 2026, and 04/01/26 - 04/15/26 revealed that the staff failed to monitor/document the PPM for the dishwasher. Review of the Satellite Kitchenettes ([NAME], [NAME], [NAME], Folly Unit) April Dish Machine Temperature Logs revealed discrepancies between PPM sanitation levels and temperature levels than what was observed during the Recertification survey. Review a [NAME] Food Services (Satellite Kitchenettes Dishwashers) Service Call Report dated 04/16/26 revealed 04/15/26 arrived on site and checked in with front desk attendant, spoke with DDS. I was shown each dishwasher needing service, 1st floor Units [NAME] and [NAME] need all new squeeze tube and [NAME] housings. The squeeze tubes failed and caused damage to housings. [NAME] temperature reach appropriate temp but [NAME] temp drop to under 120F. 2nd Floor Units [NAME] and Folly need all new squeeze tubes as well but haven't completely failed yet to damage the pump housings. Parts can be requested and aired the next day and equipment repaired as soon as possible. Observation of the [NAME]'s Unit Satellite Kitchenette Dishwasher on 04/16/26 at 11:51 AM, the dishwasher sanitation level was at 10 PPM. Appropriate level is 50-100 PPM. Observation of the [NAME] Unit Satellite Kitchenette on 04/16/26 at 11:58 AM revealed C1 using cups and plates from the dishwasher to serve residents their lunch meal. Observation of the dishwasher revealed the sanitation level below the appropriate PPM. Observation of the Folly Unit Satellite Kitchenette on 04/16/26 at 12:10 PM revealed the dishwasher not reaching the appropriate PPM. During observation C1 was observed not using the food steam table to ensure appropriate food holding temperatures, at this time all residents had been served on the unit. Follow-up observation of the [NAME]'s Unit Satellite Kitchenette on 04/16/26 at 12:17 PM revealed the dishwasher not reaching the appropriate PPM. Observation of the [NAME] Unit Satellite Kitchenette on 04/16/26 at 12:20 PM revealed the dishwasher not reaching the appropriate PPM. Observation of the Main Kitchen on 04/16/26 at 12:27 PM revealed the dishwasher not reaching the appropriate PPM. A follow-up observation and interview in the Main Kitchen on 04/16/26 at 1:20 PM with the EC revealed that the three-compartment sink is currently not in use/out of order. The EC stated that the facility utilizes the satellite kitchenette dishwashers for smaller items (plates, utensils, cups) after (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	ensure resident safety and regulatory compliance. I. Ensuring Harm Will Not Occur or Recur: To prevent recurrence regarding food procurement, store/prepare/serve – sanitary, our facility has taken immediate and ongoing actions to eliminate the risk associated with unsafe regarding food procurement, store/prepare/serve – sanitary. These steps include the reassessment of all residents at risk, reinforcement of safety measures, and staff education to ensure proper monitoring and response. All actions taken are designed to provide a safe environment while ensuring adequate food procurement and storage/preparation, and service to all at-risk residents. II. Date of Implementation: While all corrective actions were initiated immediately upon discovery of deficiency, the official implementation dates for specific actions are listed below: 1. April 16, 2026 – 12:09pm Immediately upon discovery of deficient practice the Administrator had the skilled nursing team remove all reusable flatware, cups, coffee pots, ice scoops, hydration station and supplies, plates and any other serve ware. These items were replaced with disposable counterparts for the duration of the lunch service.2. April 16, 2026 – 12:15pm Administrator had the Scheduler/Admin Assistant educate the floor team on non-use of the dishwashers until further notice. This included the use of disposables.3. April 16, 2026 – 12:19pm Director of Dining Services called [NAME] Food Service Repair to come and assess the dish machines on The Retreat skilled nursing kitchenettes (4). Director of Dining Services called Ecolab to service the Main Kitchen Dish Machine. 4. April 16, 2026 – 12:45pm Director of Dining Services went to purchase additional PPM test strips to ensure we had active strips on site. The ones on site at the time of deficient practice were identified as valid through 7/2027; the purchase of additional strips was to ensure accuracy.5. April 16, 2026 – 1:46pm Ecolab arrived on site to service the main dish machine. Technician identified a kink in the line and was able to restore the machine to full service.6. April 16, 2026 – 1:50pm Administrator informed Director of Dining Services that all dinner meals needed to be discarded and we needed to move to an alternative meal; this decision was made to ensure all cooking utensils were properly sanitized. All meals for dinner were discarded. 7. April 16, 2026 – 1:59pm Healthcare Liaison called and spoke to US Foods to confirm that our disposables were ordered as part of our standard order and would be delivered on Friday, April 17, 2026. This was completed out of an abundance of caution in the event the dish machines were not put back in service. 8. April 16, 2026 – 2:14pm Director of Dining Services informed the Chef, CDM, Administrator, and Executive Director that the new meal would be spaghetti with meat sauce, garlic bread, and broccoli – the dessert was fruit crisp. 9. April 16, 2026 – 2:24pm Administrator informed the Survey Team of the meal change.10. April 16, 2026 – 2:44pm [NAME] confirmed via email that their technician would be on site 04/16/26 to service the dish machines in The Retreat kitchenettes (4).11. April 16, 2026 – 3:00pm CDM printed new diet tickets for all meals.12. April 16, 2026 – 3:10pm [NAME] representative arrived onsite to assess the dish machines. He spoke with Director of Dining Services and then the Administrator to him to the kitchenettes. At this time, he determined that the squeeze tubes to the sanitizer needed to be replaced. He also verbally recommended the wheels on the internal squeeze tube system be replaced. 13. April 16, 2026 – 3:18pm Executive Director purchased replacement squeeze tubes for all kitchenette squeeze tubes. The estimated arrival date is 4/18/26. [NAME] will return to install once they are in house.14. April 16, 2026 – 3:35pm-5:45p Dining Team completed proper sanitization of all reusable serve ware. 15. April 16, 2026 – 3:33pm Survey Team Coordinator informed the Leadership Team that they had conferred with the DPH office and were going to call an Immediate Jeopardy citation related to the dish machine sanitization.16. April 16, 2026 – 4:37pm Executive Director notified the Medical Director that the Community was in Immediate Jeopardy.17. April 16, 2026 – 4:43pm (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Survey Team Coordinator sent Administrator the Immediate Jeopardy template, which was immediately printed and signed by the Administrator.18. April 16, 2026 – 4:49pm DPH Survey Team exited the Community at this time. 19. April 16, 2026 – 4:50pm Administrator had the clinical leadership team do an audit of all 4 kitchenettes to ensure all reusable serve ware had been removed from the kitchenettes, fridges, dish machines, sinks, residents' apartments, and common areas. All removed items were taken to the main dish machine and appropriately sanitized. 20. April 16, 2026 – 4:55pm Executive Director educated the Administrator on F812 regulations and state regulations for proper sanitation and dish machine temperatures and PPM for chemical sanitation.21. April 16, 2026 – 5:19pm Administrator had the clinical leaders and nurses on the floor assess all Members for symptoms of foodborne illness. No Members were identified to be affected by any gastrointestinal concerns. There were no past concerns of foodborne illness or associated Gastrointestinal illness symptoms; this information was reviewed by our Regional Clinical Coach by way of auditing April 2026 case list for infection control. 22. April 16, 2026 – 5:31pm Administrator notified the Ombudsman that the Community was in Immediate Jeopardy.23. April 16, 2026 – 5:45pm Administrator educated the CDM on F812 regulations and state regulations for proper sanitation and dish machine temperatures and PPM for chemical sanitation. 24. April 16, 2026 – 5:45pm Administrator educate the [Facilities] Leadership team on F812 regulations and state regulations for proper sanitation and dish machine temperatures and PPM for chemical sanitation. Administrator assigned Leadership education groups for whole house education for everyone in the community. 25. April 16, 2026 – 6:07pm Administrator, Director of Dining Services, and Executive Director received the following report from: 4-15-26 DORT. Arrived on site and checked in with front desk attendant. Spoke with [Director of Dining Services] and [Administrator]. Was shown to each dishwasher needing service. First floor dishwashers ([NAME] and [NAME]) need all new squeeze tubes and pump housings. The squeeze tubes failed and caused damage to housing. [NAME] temped correctly but [NAME] temps dropped to just under 120 degrees. Technician turned thermostat up to help it achieve better temps and it was confirmed to hold proper temperature. Element is pulling correct amp draw. Second floor dishwashers ([NAME] and Folly) need all new squeeze tubes as well but haven't completely failed yet to damage the pump housing and when verified, [NAME] and Folly dishwashers held proper temperatures. Explained my findings to [Administrator] and [Director of Dining Services]. They requested parts to be next day aired, and equipment repaired as quick as possible. Emergency repairs and express parts shipping were all authorized by Executive Director. 26. April 16, 2026 – 6:28pm-7:23pm The Leadership team began education with all team members in house on F812 regulations and state regulations for proper sanitation and dish machine temperatures and PPM for chemical sanitation. The Director of Dining Services and Executive Chef included their education in English and Spanish. The Director of Dining Services and Executive Chef also conducted education on the proper testing method of PPM and the need for this testing to be completed daily and logged. 27. April 16, 2026 – 6:33pm The Executive Director send a regroup message to all staff that included PDF versions of the Education and a summary. This Education was sent to all team members by e-mail, text, and phone.28. April 16, 2026 – 6:40pm The Executive Director sent a regroup message to all Residents, Members, Families, and Responsible parties that informed of the dishwasher concerns, the switch to disposables for lunch, the cancellation of the The Chef's Dinner, and the switch to an alternative safe meal. The message included that all meal service would continue per the norm starting 14/17/2026 and that the main dish machine would be used for cleaning of all serve ware.29. Ongoing – Administrator and/or designee will conduct weekly audits of the temperature and PPM logs for 4 weeks, then monthly x2 months. Audit results will be presented to the QAPI committee monthly. Audits will continue until 100% compliance is reached. 30. Ongoing – Director of Dining Services and/or Designee will conduct daily audits of the dish machine temperature and PPM logs weekly for 4 weeks, then monthly x2 months. Audit results will be presented to the QAPI committee monthly. Audits will continue until 100% compliance is reached. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Retreat at Wellmore of Daniel Island	580 Robert Daniel Drive Charleston, SC 29492

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	III. Identifying Those Affected or at Risk: All Members in skilled nursing had the potential to be affected. A root cause analysis was completed. IV. Systemic Process Changes to Prevent Recurrence: The facility has taken the following steps to alter systemic failures and prevent future adverse outcomes: 1. Increased Monitoring and Audits:a. CSA, DDS and/or Designee will conduct audits daily for two weeks, weekly for eight weeks, and monthly for three months or longer until 100% compliance is met to ensure proper sanitation. All negative findings will be corrected immediately. Involved Team Members will be reeducated immediately. b. We will track compliance by reviewing the audit tool. c. Audit results will be reviewed in monthly Quality Assurance (QA) meetings for further recommendations. 2. Enhanced Staff Training and Education:a. All staff will be re-educated by CSA and/or designee on F812 regulations and state regulations for proper sanitation and dish machine temperatures and PPM for chemical sanitation policies.3. Family and Resident Engagement:a. Families and residents have been provided notification on the dish machine concerns. The facility is alleging compliance as of 04/17/26.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, interviews, review of the facility policy and South Carolina Board of Nursing regulations, the facility failed to ensure that no significant medication errors occurred for 1 (Resident (R) 45) of 3 residents observed during medication pass. (Cross reference F550, F759 and F880.)Findings include: Review of the facility policy titled, Administering Medication, revised 2019 states Medications are administered with prescriber order . Review of the facility policy titled, Central Venous Catheter Flushing and Locking revised June 2025 states The purposes of this procedure are to maintain patency of central venous catheters/access devices (CVADS), prevent mixing of incompatible medications and solutions, and ensure entire dose of solution or medication is administered into the venous system. and Verify with State Nurses Practice act the scope of practice for RNs (Registered Nurses) and LPNs (Licensed Practical Nurses regarding this procedure. Review of the South Carolina Board of Nursing regulations revealed Licensed Practical Nurses (LPNs) may administer specific IV (intravenous) medications and fluids, provided they have completed specialized training and act under the direct supervision of a Registered Nurse (RN) or physician. Review of the Electronic Medical Record (EMR) revealed R45 had been admitted to the facility on [DATE] with diagnoses of septicemia and bacteremia and had been placed on enhanced barrier precautions. On 04/14/26 at approximately 10:40 AM, during medication pass observation, Licensed Practical Nurse (LPN)1 stated LPN2, was going to help him administer Rocephin [an antibiotic] to R45 through a PICC (peripherally inserted central catheter) line, because he had not given medications this way before. On 04/14/26 at approximately 10:48 AM, LPN1 and LPN2 went to R45 who was sitting in the common area and administered Heparin Lock Flush 50 USP (United States Pharmacopeia)/5 ml (milliliters) into the PICC line first, then secondly administered Normal Saline (Sodium Chloride) 0.9% (percent), 10 ml and lastly attached ceftriaxone (Rocephin) 2 Grams contained in a premixed [NAME] intravenous infusion container to the PICC line. During administration of these three medications, neither LPN1 nor LPN2 were wearing PPE (personal protective equipment) and both touched R45. During administration of these three medications, four staff members and one visitor walked by in the hallway while looking into the common area while the medications were being administered. On 04/14/26 at 10:56 AM, LPN1, when asked, verified R45 was in a common area, that PPE had not been used when the 3 medications had been administered to R45 and acknowledged that Heparin had been given first, then Normal Saline prior to the Rocephin (ceftriaxone) being administered. On 4/14/26 at approximately 11:06 AM, during medication reconciliation, a review of the EMR (electronic medical record) revealed an order for Ceftriaxone Sodium Solution reconstitute 2 Gm (grams), Use 2 gram intravenously every 24 hours for infection for 14 days dated 4/7/2026 08:00, but there were no physicians order for Heparin or Normal Saline. On 04/15/26 at approximately 10:40 AM, further review of the EMR revealed a physician's order dated 4/15/2026 10:30 which read SASH (Saline - Administer - Saline -Heparin) Protocol: Please ensure SASH protocol is followed for central line infusions. Scrub lumen hub 10 ml normal saline flush before medication administration Scrub lumen hub Administer Medication Disconnect medication Scrub lumen hub give 10 ml normal saline flush after medication Scrub lumen hub Give 5ml (50 units) Heparin flush (as ordered Place Kuros disinfectant cap over lumen(s). On 04/15/26 at approximately 12:25 PM, Registered Nurse (RN)1 stated the facility has a training issue with batch orders causing them not to populate standing physician orders to the EMR. He acknowledged he had entered standing orders (SASH) for R45 today and that there were none in the EMR on 4/14/26 at the time the 3 medications had been administered. When he was informed by the Surveyor that Heparin had been administered first, then Normal Saline, he stated that was not how it should be done. On 04/16/26 at approximately 9:04 AM, LPN1 stated there was no order on the MAR (medication administration record) for Heparin or Normal Saline related to the Rocephin order and was unclear as to how he had chosen to administer those 2 medications. He stated again that he had never (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	given an intravenous drug through a PICC line and that's why he had asked LPN2 to help him. He stated he had been trained on resident privacy, enhanced barrier precaution, but had not been trained on intravenous drug administration. On 04/16/26 at approximately 11:07 AM, RN2, the Director of Nursing (DON), stated there was no order for Heparin or Normal Saline in the system at the time the medications were administered on 04/14/26 and that LPN2, an agency nurse, was failing to have orders, including batch orders entered and double checked into the EMR. On 04/17/26 at approximately 8:48 AM during a telephone interview, RN2 (DON) stated again that LPN2 is an agency nurse and that she has no knowledge of LPN2 having received any training related to administering intravenous medications and that when LPN1 asked for help because of his inexperience, he asked the wrong person.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and review of facility policy, the facility failed to ensure meals were served according to the prescribed diets during two lunch meals for Resident (R) 33. Findings Include:Review of the facility policy titled, Tray Identification, with a revised date of 04/07, revealed, 2. The Food Services Manager will check trays for correct diets before the food carts are transported to their designated areas. 3. Nursing staff shall check each food tray for the correct diet before serving the residents.Review of R33's face sheet revealed he was admitted to the facility on [DATE]. His diagnoses included, but were not limited to, cerebral infarction (stroke), cerebellar stroke syndrome, dementia, and dysphagia (difficulty swallowing). Review of R33's annual Minimum Data Set (MDS) with an Assessment Review Date (ARD) of 04/06/26 revealed R33 had a Brief Interview for Mental Status (BIMS) score of 07/15, which indicated R33 had severe cognitive deficit. R33 needed setup assistance with eating and experienced coughing or choking during meals. Review of R33's care plan revealed R33 was at risk for alteration in nutrition related to cerebellar stroke syndrome, swallowing issues, use of mechanically altered diet, and consuming less than 75% of his meals. On 04/07/26, the goal was updated to include a regular, mechanical soft (ground meats), nectar thickened liquid diet. Review of R33's orders revealed an order dated 03/12/26 for a regular diet, mechanical soft with ground meats texture, nectar/mildly thick consistency. An order for aspiration (when food or liquid enters the windpipe or lungs) precautions was dated 04/14/26. During an observation on 04/15/26 at 11:25 AM, R33's lunch ticket read, Regular diet, Mechanical soft ground meat, Mildly thick (2)/ Nectar liquids. The ticket also read, Ground Fish Creole, Garden vegetable (d/s), Buttered corn bread, Milk/Beverage - Nectar/ Mild Thick (2), and Swirl pudding parfait as the specific food to be served for that meal. R33's plate contained an intact filet of fish creole (not ground). Surveyor showed Certified Nursing Assistant (CNA)3 R33's plate, and she immediately removed the plate from R33. During an observation on 04/16/26 at 11:45 am, R33's lunch ticket read, Ground Beef & Bean Chili - Nectar/ Mild Thick, Soft cauliflower with cheese sauce, Yellow rice with gravy, Milk/ Beverage- Nectar/ Mild Thick, Soft mixed berry cobbler. R33's plate contained a pile of dark brown semi-solid substance with beans and rice kernels scattered throughout. The cauliflower with cheese sauce and yellow rice with gravy were missing from the plate. When R33 saw the food on his plate, he stated, What is this crap? Surveyor showed CNA3 R33's plate. She immediately removed the plate from the Resident. Surveyor attempted to speak with the [NAME] regarding the meal served to R33. She replied multiple times, He wants it separate? and walked away. During an interview on 04/17/26 at 8:40 AM, Surveyor spoke with the Executive Chef (EC) about R33's meals. The EC revealed he had always been told at this facility that fish is soft enough to be served whole even for residents who have Ground listed on their ticket. He revealed that any meats, chicken, breaded fish, and shrimp are always chopped or ground when ordered. He revealed R33's meal on 04/16/26 should not have been served mixed together. He stated the dietary aides mixed everything together, and he was not sure why because they had been instructed not to do that. He revealed would follow up with the dietary aides to reinforce that meals should not be served that way. During an interview on 04/17/26 at approximately 10:00 AM, CDM revealed she handles more of the dietary clinical issues, and the EC oversees the kitchen. She stated she does assist with meal prep and overseeing plating when needed and when she is in the kitchen. The CDM stated that R33's fish on 04/15/26 should have been ground and verified what was served was not what was listed on the ticket. She revealed R33's lunch on 04/16/26 should not have been served with the mixed.During an interview on 04/17/26 at 10:30 AM, The Administrator stated her expectation that the meal served matches the meal ticket and consistency of the resident's diet. At the end of the day, the meal has to match the ticket.During an interview on 04/17/26 at 12:00 PM with The Dietician, she revealed the (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility's belief is if the fish is soft and can be flaked, it can be served whole for dignity and palatability, and she has instructed this to the kitchen staff.During an interview on 04/17/26 at 12:30 PM with The Speech Therapist (ST), she revealed she had treated R33 and was familiar with his medical history. She revealed a ground diet means the food should fit through the tines of a fork. The ST stated she has worked in places where intact fish filets were served to Residents on a ground diet, but the staff flaked the fish immediately after serving the meal because the ability of the Residents to flake the fish appropriately could not be assured. The ST verified that R33's lunch meal on 04/15/26 did not meet the criteria for ground.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews the facility failed to ensure that privacy was maintained while intravenous medications were being administered to 1 (Resident (R) 45) of 3 residents observed during medication pass. (Cross reference F759, F760 and F880.)Findings include: Review of the facility policy titled, Dignity revised February 2022, states Resident are treated with dignity and respect at all times. No policy on Privacy was obtained during the survey process. Review of the Electronic Medical Record (EMR) revealed R45 had been admitted to the facility on [DATE] with diagnoses of septicemia and bacteremia and had been placed on enhanced barrier precautions (EBP). On 04/14/26 at approximately 10:40 AM, during medication pass observation, Licensed Practical Nurse (LPN)1 stated LPN2 was going to help him administer Rocephin [an antibiotic] to R45 through a PICC (peripherally inserted central catheter) line, because he had not given medications this way before. On 04/14/2026 at approximately 10:48 AM, LPN1 and LPN2 went to R45, who was sitting in the common area and administered Heparin Lock Flush 50 USP (United States Pharmacopeia)/5 ml (milliliters) into the PICC line first, then administered Normal Saline (Sodium Chloride) 0.9% (percent), 10 ml and lastly, attached Ceftriaxone (Rocephin) 2 Grams contained in a premixed [NAME] intravenous infusion container, to the PICC line. During administration of these three medications, neither LPN1 nor LPN2 were observed wearing PPE (personal protective equipment) and both had physically touched R45. During administration of these three medications, four staff members and one visitor walked by in the hallway, while looking into the common area, while the medications were being administered. During an interview on 04/14/26 at 10:56 AM, LPN1, when asked, verified R45 was in a common area when medications were administered and privacy had not been provided.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, interviews and facility policy, the facility failed to ensure that medications were administered pursuant to physician orders for 1 (Resident (R) 45) of 3 residents observed during medication pass. The medication error rate was 8 percent. (Cross reference F550, F760 and F880.)Findings include: Review of the facility policy titled, Administering Medication, revised 2019 states Medications are administered with prescriber order . Review of the Electronic Medical Record (EMR) indicated R45 had been admitted to the facility on [DATE] with diagnoses of septicemia and bacteremia and had been placed on enhanced barrier precautions. On 04/14/26 at approximately 10:40 AM, during medication pass observation, Licensed Practical Nurse (LPN)1 stated LPN2, was going to help him administer Rocephin [an antibiotic] to R45 through a PICC (peripherally inserted central catheter) line because he had not given medications this way before. On 04/14/26 at approximately 10:48 AM, LPN1 and LPN2 went to R45, who was sitting in the common area and administered Heparin Lock Flush 50 USP (United States Pharmacopeia)/5 ml (milliliters) into the PICC line first, then secondly administered Normal Saline (Sodium Chloride) 0.9% (percent), 10 ml and lastly, attached Ceftriaxone (Rocephin) 2 Grams contained in a premixed [NAME] intravenous infusion container to the PICC line. During administration of these three medications, neither LPN1 nor LPN2 were wearing PPE (personal protective equipment) and both physically touched R45. During administration of these 3 medications, four staff members and one visitor walked by in the hallway, while looking into the common area, while the medications were being administered. On 04/14/26 at 10:56 AM, LPN1, when asked, verified R45 was in a common area, that PPE had not been used when the three medications had been administered to R45 and acknowledged that Heparin had been given first, then Normal Saline prior to the Rocephin (Ceftriaxone) being administered. On 4/14/26, at approximately 11:06 AM, during medication reconciliation, a review of the EMR revealed an order for Ceftriaxone Sodium Solution reconstitute 2 Gm (grams), Use 2 grams intravenously every 24 hours for infection for 14 days dated 4/7/2026 at 08:00, but there were no Physician's orders for Heparin or Normal Saline. On 4/15/26 at approximately 10:40 AM, further review of the EMR revealed a Physician's order dated 4/15/26 at 10:30 AM, which read SASH (Saline - Administer - Saline -Heparin) Protocol: Please ensure SASH protocol is followed for central line infusions. Scrub lumen hub 10 ml normal saline flush before medication administration Scrub lumen hub Administer Medication Disconnect medication Scrub lumen hub give 10 ml normal saline flush after medication Scrub lumen hub Give 5ml (50 units) Heparin flush (as ordered Place Kuros disinfectant cap over lumen(s). On 04/15/26 at approximately 12:25 PM, Registered Nurse (RN)1 stated the facility has a training issue with batch orders causing them not to populate standing physician orders to the EMR. He acknowledged he had entered standing orders (SASH) for R45 today and that there were none in the EMR on 4/14/26 at the time the 3 medications had been administered. When he was informed by the Surveyor that Heparin had been administered first, then Normal Saline, he stated that was not how it should be done. On 04/16/2026 at approximately 9:04 AM, LPN1 stated there was no order on the MAR (medication administration record) for Heparin or Normal Saline related to the Rocephin order and was unclear as to how he had chosen to administer those 2 medications. He stated again that he had never given an intravenous drug through a PICC line and that's why he had asked LPN2 to help him. He stated he had been trained on resident privacy, enhanced barrier precaution, but had not been trained on intravenous drug administration. On 04/16/26 at approximately 11:07 AM, RN2, the Director of Nursing (DON), stated there was no order for Heparin or Normal Saline in the system at the time the medications were administered on 04/14/26 and that LPN2, an agency nurse, was failing to have orders, including batch orders entered and double checked into the EMR.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, interviews, and review of manufacturer labeling, the facility failed to ensure that medications were properly stored in 1 of 4 treatment carts.Findings Include: During an observation on 04/15/26 at approximately 11:32 AM, the [NAME] treatment cart contained one opened container of [NAME] Normal Saline 0.9 percent (0.9%), 100 milliliters (100 mL). The container was dated by the facility as opened on 04/10/2026. The manufacturer's labeling on the container stated Do Not Reuse and Contents STERILE in unopened.package. During a follow-up interview on 04/15/26 at approximately 11:37 AM, Licensed Practical Nurse 3 (LPN 3) inspected the [NAME] Normal Saline container, read the manufacturer's labeling, and stated that it should have been discarded after use rather than being returned to the treatment cart.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, interviews and review of the facility policy, the facility failed to ensure enhanced barrier precautions were followed for 1 (Resident (R) 45) of 3 residents observed during medication pass. (Cross reference F550, F759 and F760). Findings Include:Review of the facility policy titled, Enhanced Barrier Precautions, last revised August 2022, states, Policy Interpretation and Implementation: 1. Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: . g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.) 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.Review of the facility policy titled, Infection Prevention and Control Program last revised October 2018 states, Prevention of Infection: a. Important facets of infection prevention include. (3) educating staff and ensuring that they adhere to proper techniques and procedures. (7) implementing appropriate isolation precautions when necessaryReview of the Electronic Medical Record (EMR) revealed R45 had been admitted to the facility on [DATE] with diagnoses of septicemia and bacteremia and had been placed on enhanced barrier precautions (EBP).During an observation of medication administration on 04/14/26 at approximately 10:40 AM, Licensed Practical Nurse (LPN) 1 stated LPN 2, was going to help him administer Rocephin to R45 through a PICC (peripherally inserted central catheter) line because he had not given medications this way before. At approximately 10:48 AM LPN 1 and LPN 2 went to R45 who was sitting in the common area and administered Heparin Lock Flush 50 USP (United States Pharmacopeia)/5 ml (milliliters) into the PICC line first, then secondly administered Normal Saline (Sodium Chloride) 0.9% (percent), 10 ml and lastly attached ceftriaxone (Rocephin) 2 Grams contained in a premixed [NAME] intravenous infusion container to the PICC line. During the administration of these 3 medications, neither LPN 1 nor LPN 2 were wearing PPE (personal protective equipment) and both touched R45.During an interview on 04/14/26 10:56 AM, LPN 1, when asked, verified R45 was in a common area, that PPE had not been used when the 3 medications had been administered to R45.During an interview on 04/16/26 at approximately 9:04 AM, LPN 1 stated again that he had never given an intravenous drug through a PICC line and that's why he had asked LPN 2 to help him. He stated he had been trained in EBP's but had not been trained on intravenous drug administration.During a telephone interview on 04/17/26 at approximately 8:48 AM, RN 2 (DON) stated again that LPN 2 is an agency nurse and that she has no knowledge of LPN 2 having received any training related to administering intravenous medications and that when LPN 1 asked for help because of his inexperience, he asked the wrong person.