STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445515	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Tullahoma	1321 Cedar Lane Tullahoma, TN 37388

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual, medical record review and interview, the facility failed to complete quarterly assessments, using the Centers for Medicare & Medicaid Services specified RAI process, within the regulatory time frames for 7 residents (Resident #19, #21, #48, #62, #82, #85 and #95) of 28 sampled residents reviewed for MDS assessment. The findings include: Review of the MDS 3.0 RAI Manual v (version) 1.19.1, dated 10/2024, pages 2-35, revealed, .The Quarterly assessment is an OBRA (Omnibus Budget Reconciliation Act) non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored .The MDS completion date must be no later than 14 days after the ARD [Assessment Reference Date] . 1. Review of the medical record revealed Resident #19 was admitted to the facility on [DATE] with diagnoses including Heart Failure, Hypertension and Anxiety Disorder. Review of Resident #19's quarterly MDS assessment dated [DATE], revealed item Z0500B was undated, and should have been completed by 5/16/2025. 2. Review of the medical record revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including Dementia, Chronic Kidney Disease and Encounter for Palliative Care. Review of Resident 21's quarterly MDS dated [DATE], revealed item Z0500B was completed 6/9/2025, and should have been completed by 5/6/2025. 3. Review of the medical record revealed Resident #48 was admitted to the facility on [DATE] with diagnoses including Dementia, Heart Failure and Chronic Kidney Disease. Review of Resident #48's quarterly MDS assessment dated [DATE], revealed item Z0500B was completed on 6/6/2025, and should have been completed by 4/26/2025. 4. Review of the medical record revealed Resident #62 was admitted to the facility on [DATE] with diagnoses including Polyneuropathy, Adult Failure to Thrive and Depression. (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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #62's quarterly MDS assessment dated [DATE], revealed item Z0500B was completed on 6/9/2025, and should have been completed by 5/16/2025. 5. Review of the medical record revealed Resident #82 was admitted to the facility on [DATE] with diagnoses including Diabetes, Hypertension and Anxiety Disorder. Review of Resident #82's quarterly MDS assessment dated [DATE], revealed item Z0500B was completed on 6/10/2025, and should have been completed by 5/20/2025. 6. Review of the medical record revealed Resident #85 was admitted to the facility on [DATE] with diagnoses including Heart Failure, Dementia and Depression. Review of Resident #85's quarterly MDS assessment dated [DATE], revealed item Z0500B was completed on 6/9/2025, and should have been completed by 5/2/2025. 7. Review of the medical record revealed Resident #95 was admitted to the facility on [DATE] with diagnoses including Heart Failure, Anxiety Disorder and Chronic Kidney Disease. Review of Resident #95's quarterly MDS assessment dated [DATE], revealed item Z0500B was completed on 6/10/2025, and should have been completed by 5/7/2025. During an interview on 6/11/2025 at 8:49 AM, the MDS Coordinator J and MDS Coordinator K were asked who signs MDS assessments verifying they are complete. MDS Coordinator J stated, I do. MDS Coordinator J confirmed Residents #19, #21, #48, #62, #82, #85, and #95 had assessments completed late. The MDS Coordinator J confirmed quarterly assessments should be completed 14 days after the ARD.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation and interview, the facility failed to revise the care plan for 1 resident (Resident #5) of 18 residents reviewed for care plans. The findings include: Review of the facility's policy, Documentation Guidelines, updated 5/2024, revealed .The center .ensure an interdisciplinary and comprehensive approach .development of patient's care plan of care .updating .care plans .problems are handled as they arise .added to current care plan . Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including Heart Failure, Malignant Neoplasm of Pancreas and Anxiety. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #5 scored an 11 on the Brief Interview for Mental Status (BIMS) assessment which indicated moderate cognitive impairment. Review of the comprehensive care plan for Resident #5 dated 5/15/2025, revealed .Indwelling Catheter . Review of the medical record revealed Resident #5 had a indwelling urinary catheter placed on 5/15/2025. Further review revealed Resident #5 was sent to the hospital on 5/26/2025. Continued review revealed Resident #5 was readmitted to the facility on [DATE] without an indwelling urinary catheter. During an observation on 6/9/2025 at 10:22 AM, Resident #5 was lying in bed and no indwelling urinary catheter was present. During an observation on 6/10/2025 at 8:10 AM, Resident #5 was lying in bed and no indwelling urinary catheter was present. During an interview on 6/10/2025 at 9:00 AM, Registered Nurse (RN) I stated Resident #5 did not have an indwelling urinary catheter. During an interview on 6/11/2025 at 2:36 PM, the Director of Nursing confirmed Resident #5's care plan had not been revised to reflect the discontinuation of the indwelling urinary catheter.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility document review, observations and interviews, the facility failed to ensure medications were stored and secured properly for 2 residents (Resident #5 and #219) of 90 residents observed. The findings include: Review of the facility's policy, Medication Storage in the Facility, updated 2/25/2025, revealed .Medications . stored safely .securely .and properly .medication supply .accessible only to licensed nursing personnel . medications .stored in medication cart . Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including Heart Failure, Malignant Neoplasm of Pancreas and Anxiety. Review of a physician's order for Resident #5 dated 6/2/2025, revealed .Incruse Ellipta [medication used to treat chronic respiratory conditions] .62.5 mcg [microgram] .1 puff once a day . Review of the Medication Administration Record (MAR) for Resident #5 dated 6/2/2025-6/10/2025, revealed the resident received .Incruse Ellipta .62.5 mg .1 puff . on 6/9/2025 at 8:30 AM. During an observation on 6/9/2025 at 10:00 AM, revealed Resident #5 was lying in bed and there was an Incruse Ellipta inhaler placed on the bedside table. During an observation and interview on 6/9/2025 at 10:22 AM, with Registered Nurse (RN) I, in Resident #5's room, revealed there was an Incruse Ellipta inhaler on the bedside table. RN I confirmed she had administered the resident's dose of Incruse Ellipta and had left the inhaler lying on the bedside table. RN I confirmed medications were not to be left at the bedside unless the resident had been assessed for self-administration. RN I stated she could not find in the medical record whether Resident #5 had been assessed for self-administration of medications. During an interview on 6/11/2025 at 12:33 PM, the Medical Director stated Incruse Ellipta .highly unlikely that any resident could get it open and operate correctly . The Medical Director stated ingestion would not be detrimental to health of any patient. During an interview on 6/11/2025 at 1:00 PM, the Pharmacy Consultant stated the toxicity from Incruse Ellipta would be rare and not detrimental to the health of any patient. Review of the medical record revealed Resident #219 was admitted to the facility on [DATE] with diagnoses including Aftercare Following Joint Replacement Surgery and Emphysema. Review of a physician's order for Resident #219 dated 6/5/2025, revealed .Budesonide [inhaled steroid medication] .suspension for nebulization; 0.5 mg [milligram]/ [in] 2 mL[milliliters] .inhalation .Twice a Day . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the comprehensive care plan for Resident #219 dated 6/6/2025, revealed .At risk for respiratory complications related to .emphysema .Nebulizer treatments: rinse mask and reservoir with water. place on dry clean barrier until dry then place in bag . Review of the Medication Administration Record (MAR) for Resident #219 dated 6/1/2025 - 6/10/2025, revealed the resident received .Budesonide .suspension for nebulization .0.5 mg/2 mL . on 6/9/2025 at 8:30 AM. During an observation on 6/9/2025 at 10:40 AM, revealed Resident #219 was lying in bed and there was 1 unopened vial of Budesonide Inhalation Suspension 0.5 mg/2 ml on the beside table. During an observation and interview on 6/9/2025 at 1:20 PM, with Licensed Practical Nurse (LPN) H, in Resident #219's room, revealed there was 1 unopened vial of Budesonide Inhalation Suspension 0.5 mg/2 ml lying on the beside table. LPN H confirmed she had administered the resident's dose of Budesonide this morning (6/9/2025) and had not noticed the unopened vial lying on the bedside table. LPN H confirmed medications were not to be left at the bedside unless the resident had been assessed for self-administration. LPN H stated she could not find in the medical record whether Resident #219 had been assessed for self-administration of medications. During observations on 6/9/2025 through 6/11/2025, revealed no residents wandering in the facility. During an interview on 6/11/2025 at 1:53 PM, the Pharmacy Consultant stated Budesonide is an inhaled steroid medication. The Pharmacy Consultant stated the potential for acute toxicity was rare and stated it was .very unlikely a patient could get it open . and if they did .very unlikely to cause any harm . During an interview on 6/11/2025 at 2:15 PM, the Director of Nursing (DON) confirmed Resident #5 and Resident #219 had not been assessed for self administration of medications and confirmed medications left at the bedside were not secured or stored properly.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation and interview, the facility failed to ensure a nebulizer mask was stored appropriately for 1 resident (Resident #219) of 3 residents observed on nebulized medications. The findings include: Review of the facility's policy, Specific Medication Procedures .Oral Inhalation Administration, revised 2/25/2025, revealed .Turn on the nebulizer and check outflow port for visible mist .Remain with the resident for the treatment .Administer therapy until medication is gone .When treatment is complete, turn off nebulizer and disconnect .When equipment is completely dry, store in a plastic bag with the resident's name and date on it . Review of the medical record revealed Resident #219 was admitted to the facility on [DATE] with diagnoses including Aftercare Following Joint Replacement Surgery and Emphysema. Review of a physician's order for Resident #219 dated 6/5/2025, revealed .albuterol sulfate [a medication used to relax the muscles in the airway to increase air flow to the lungs] .solution for nebulization .2.5 mg [milligrams]/[in] 3 mL [milliliters] (0.083%) .1 neb [nebulizer] .inhalation .for sob or wheezing .Every 6 Hours . PRN [as needed] . and .budesonide [an inhaled steroid medication] .suspension for nebulization; 0.5 mg/2 mL .inhalation .Twice a Day . Review of the comprehensive care plan for Resident #219 dated 6/6/2025, revealed .At risk for respiratory complications related to .emphysema .Nebulizer treatments: rinse mask and reservoir with water. place on dry clean barrier until dry then place in bag . Review of the Medication Administration Record (MAR) dated 6/1/2025 - 6/10/2025, revealed Resident #219 received .Budesonide .suspension for nebulization .0.5 mg/2 mL . on 6/9/2025 at 8:30 AM and 5:00 PM and 6/10/2025 at 8:30 AM. During an observation on 6/9/2025 at 10:40 AM, revealed Resident #219 was lying in bed. There was a nebulizer mask hooked to the nebulizer machine lying on the table beside the bed uncovered and open to air. During an observation and interview on 6/9/2025 at 1:20 PM, with Licensed Practical Nurse (LPN) H, in Resident #219's room, revealed there was a nebulizer mask lying on the table beside the bed uncovered and open to air. LPN H confirmed Resident #219's nebulizer mask was lying on the table uncovered and open to air. LPN H confirmed the nebulizer mask was not stored appropriately and should have been placed in a bag after use. During an interview on 6/9/2025 at 2:43 PM, the Infection Preventionist (IP) confirmed nebulizer masks were to be stored in a storage bag when not in use.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on facility policy review, observation and interview, the facility failed to ensure dietary workers wore protective hair coverings during food preparation in the kitchen, which had the potential to affect 89 of 90 residents residing in the facility. The findings include: Review of the facility's policy, Hygienic & Safety Practices, dated 11/2017, revealed .provide a safe product for all customers .wear hair restraints such as hats, hair coverings, or nets, beard restraints .worn effectively to keep their hair from contacting exposed food . During an observation in the food preparation area on 6/9/2025 at 9:22 AM, the Assistant Dietary Manager (ADM) was preparing desserts for the lunch meal service. Further observation revealed the ADM had hair protruding from her protective hair covering which allowed hair from her forehead and the back of the head to remain uncovered. During an observation in the food preparation area on 6/9/2025 at 11:13 AM, the Lead [NAME] was plating resident meals for the lunch meal service and did not have on a protective beard covering to cover his facial hair. During an observation on 6/9/2025 at 11:15 AM, the ADM was preparing salads for the lunch meal service. Further observation revealed the ADM had hair protruding from the protective hair covering which allowed hair from her forehead and the back of the head to remain uncovered. During an interview on 6/9/2025 at 11:22 AM, the Food and Nutrition Director (FND) stated all dietary workers should have the hair completely covered while in the food preparation areas in the kitchen. The FND confirmed the Lead [NAME] and the ADM failed to ensure their hair was appropriately covered while preparing food in the kitchen for the residents.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on facility policy review, observations and interviews, the facility failed to ensure garbage and refuse were properly contained and failed to ensure the outside dumpster area was maintained in a sanitary and orderly condition. The findings include: Review of the facility's policy, Waste Management, dated 11/2017, revealed .refuse containers and dumpsters kept outside the facility shall .be in a safe and sanitary manner .checked routinely for .debris . items shall be removed from premises that will minimize the development of odors and other conditions that attract or harbor insects and rodents . During an observation of the outside dumpster area on 6/9/2025 at 9:32 AM, with the Food and Nutrition Director (FND) revealed 2 dumpsters (dumpster A and dumpster B) for waste disposal. Further observation revealed the area behind dumpster A and B had 4 broken wooden pallets, 1 broken chair, 1 broken television, 1 broken table, and 15 disposable gloves on the ground. During an interview on 6/9/2025 at 9:34 AM, the FND stated the 4 broken wooden pallets, 1 broken chair, 1 broken television, 1 broken table, and 15 disposable gloves were not disposed properly and was unsure how long those items had been there. The FND confirmed the dumpster area had not been maintained in a sanitary condition. During an interview on 6/9/2025 at 9:36 AM, the Maintenance Assistant confirmed the dumpster area was not maintained in a sanitary condition.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, facility contract review, medical record review, observation and interview, the facility failed to ensure a coordinated plan of care with the hospice provider was available in the medical record for 1 resident (Resident #111) of 4 residents reviewed for hospice services. The findings include: Review of the facility's undated policy, HOSPICE SERVICES, revealed .the hospice will guide the plan of care in collaboration with the center . Review of the facility's hospice contract with the hospice entity providing care for Resident #111, dated 10/11/2013, revealed .Plan of Care .means a written care plan established, maintained, reviewed and modified .the Plan of Care includes .an identification of the Hospice Services .detailed statement of the scope and frequency of such Hospice Services .Hospice and Facility will jointly develop and agree upon a coordinated Plan of Care which is consistent with the hospice philosophy and is responsive to the unique needs of Hospice patient .The Plan of Care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Plan of Care .Facility shall comply with Hospice Patient's Plan of Care . Review of the medical record revealed Resident #111 was admitted to the facility on [DATE] with diagnoses including Traumatic Subdural Hemorrhage with Loss of Consciousness and Dementia. Review of a physician's order for Resident #111 dated 5/16/2025, revealed .Admit to .Hospice to provide services with dx [diagnosis] of Traumatic Subdural Hemorrhage . Review of a hospice provider's order for Resident #111 dated 5/16/2025, revealed .Admit to [named hospice provider] .Dx .Traumatic Subdural Hemorrhage . Review of the medical record revealed there was no hospice provider's plan of care present in Resident #111's medical record. Review of the comprehensive care plan dated 5/19/2025, revealed .Terminal Diagnosis/Hospice .Traumatic subdural hemorrhage .Develop a coordinated care plan . Review of the significant change Minimum Data Set assessment dated [DATE], revealed Resident #119 received hospice care at the facility. During an interview on 6/11/2025 at 5:11 PM, Registered Nurse (RN) L stated she was unaware how to locate the hospice provider's plan of care. During an interview on 6/11/2025 at 5:22 PM, the Director of Nursing (DON) stated she was unaware how to locate the hospice provider's plan of care in the medical record. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/2025 at 5:27 PM, Licensed Practical Nurse (LPN) Unit Manager M stated Resident #111 was admitted to the facility on [DATE] and admitted to hospice services on 5/16/2025 for a Subdural Hemorrhage. LPN Unit Manager M stated hospice documentation was in computer chart and confirmed Resident #111's medical record did not contain the hospice provider's plan of care. During an observation on 6/11/2025 at 5:49 PM, Resident #111 was lying in bed watching television. Resident #111 appeared comfortable with no concerns noted. During an interview on 6/11/2025 at 6:05 PM, the DON confirmed the hospice provider's plan of care was to be available in the medical record.

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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 facility policy review, medical record review, observation and interview, the facility failed to ensure appropriate Personal Protective Equipment (PPE) was donned for 2 residents (Residents #218 and #221) of 6 residents observed on Enhanced Barrier Precautions (EBP) and failed to offer hand hygiene assistance prior to meals to 3 residents (Residents #32, #89, and #62) on 1 of 6 hallways observed for meal tray distribution. The findings include: Review of the facility's policy, INFECTION CONTROL MANUAL VOLUME 1, reviewed 2/2025, revealed . Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and glove use during high contact activities .used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact patient care activities that provide opportunities for transfer of MDRO to staff hands and clothing .EBP are indicated for patients with .Wounds and/or indwelling medical devices even if the patient is not known to be infected or colonized with a MDRO .Providers and partners must wear gloves and a gown for the following High-Contact Patient Care Activities .Dressing .Bathing/ Showering . Transferring .Changing Linens .Providing hygiene .Changing briefs or assisting with toileting .Device care or use: central line, urinary catheter, feeding tube, tracheostomy .Indwelling Medical Devices .urinary catheters, feeding tubes .peripherally inserted central lines .Centers have discretion on how to communicate to staff which patients require the use of PPE . Review of the facility's policy, Safety & Sanitation Best Practice, dated 11/2017, revealed .Effective personal hygienic and safety practices are essential in preventing food contamination . Review of the medical record revealed Resident #218 was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Cognitive Communication Deficit, Dysphagia and Gastrostomy Status - Feeding Tube. Review of a physician's order for Resident #218 dated 5/29/2025, revealed .Connect Tube Feeding . Continuous x [times] 20 hours .Once A Day .Disconnect Tube Feeding x4 hours .Once A Day . Review of the comprehensive care plan for Resident #218 dated 5/29/2025, revealed .Infection risk requiring Enhanced Barrier Precautions: at risk for infection/complications .required Enhanced Barrier Precautions (EBP) due to PEG [percutaneous endoscopic gastrostomy tube] tube; Wear gloves and gown when engaging in high contact patient care activities including dressing, bathing/ showering, transferring, changing linens, providing hygiene, changing briefs / assisting with toileting . During an observation on 6/9/2025 at 11:11 AM, revealed a small sign posted on the outside of Resident #218's door that read EBP. Observation continued inside the room and revealed there was no PPE container. Resident #218 was lying in bed and had Nutren 1.5 (tube feeding formula) infusing at 60 milliliters (ml)/hour with a water flush infusing at 50 ml/hour. Resident #218 pushed the call light and requested to be repositioned at 11:13 AM. Certified Nursing Assistant (CNA) B and Licensed Practical Nurse (LPN) C entered the room at 11:15 AM. CNA B and LPN C repositioned the resident in bed wearing gloves, but did not wear gowns during the resident care interaction. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445515	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Tullahoma	1321 Cedar Lane Tullahoma, TN 37388

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/9/2025 at 11:19 AM, CNA B confirmed Resident #218 was on EBP. CNA B was unaware why the resident was on EBP and stated gown, gloves, and mask were to be worn .for any kind of contact .patient care . for residents on EBP. CNA B confirmed she had not worn a gown to reposition Resident #218 in the bed. During an observation and interview on 6/9/2025 at 11:24 AM, in Resident #218's room, LPN C confirmed Resident #218 had a feeding tube and was on EBP. Continued interview revealed LPN C stated residents with feeding tubes required EBP which included a gown and gloves only when providing direct care for the feeding tube and not while repositioning, bathing, or transferring. LPN C confirmed she had not worn a gown to reposition Resident #218 in the bed. During an interview on 6/9/2025 at 2:43 PM, the Infection Preventionist (IP) stated residents with any kind of invasive device including PEG tubes (feeding tubes, PICC (peripherally inserted central catheter) lines, and indwelling urinary catheters required the use of EBP during care. Residents on EBP required gown and gloves for direct patient contact including invasive device care, transferring and repositioning. The IP confirmed Resident #218 had a PEG tube and required staff to wear a gown and gloves for repositioning. Review of the medical record revealed Resident #221 was admitted to facility on 6/3/2025 with diagnoses including Osteomyelitis of Vertebra, Muscle Wasting and Atrophy, Neuromuscular Dysfunction of Bladder and Encounter for Adjustment and Management of Vascular Access Device-PICC Line. Review of a physician's order for Resident #221 dated 6/3/2025, revealed .cefepime [antibiotic medication] .1 gram .intravenous .Every 6 Hours .PICC site: Left Upper Arm .Every Shift .Observe PICC site for S&S [signs/symptoms] of infection, infiltration, and that dressing is dry and intact .Indwelling urinary catheter . catheter care every shift .EBP: Patient is to be on enhanced barrier precautions due to PICC LINE AND FOLEY CATHETER .Patient requires enhanced barrier precautions. Wear gloves and a gown when engaging in high contact patient care . Review of the comprehensive care plan for Resident #221 dated 6/3/2025, revealed .Enhanced Barrier Precautions .in addition to standard precautions, use enhanced barrier precautions (EBP) during high-contact patient care activities that provide opportunities for transfer of multi-drug resistant organisms (MDROs) to partner hands or clothing .requires .(EBP) due to PICC line and foley catheter; Wear gloves and gown when engaging in high contact patient care activities including dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs/assisting with toileting . During an observation on 6/10/2025 at 8:59 AM, there was a sign posted on the outside of Resident #221's room that read EBP. CNA A and CNA D entered Resident #221's room and changed Resident #221's bed linens. The CNAs did not wear gloves or gown while changing the linens. During an interview on 6/10/2025 at 9:02 AM, CNA A and CNA D confirmed Resident #221 was on EBP due to a catheter. The CNAs confirmed they had changed the resident's linens and did not wear gown or gloves. The CNAs confirmed they should have worn a gown and gloves to change Resident #221's linens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/10/2025 at 9:03 AM, Resident #221 was seated in the wheelchair beside the bed. Resident #221 had a catheter in a dignity bag with clear yellow urine and a PICC line in the left upper arm with a clean and intact dressing dated 6/7/2025. There was a PPE container hanging on the back of the resident's door that contained gowns and gloves. During an interview on 6/10/2025 at 2:46 PM, the IP stated the resident was on EBP for a PICC line and catheter and required gloves and gown for linen change regardless of if the resident is in the bed or not. During an observation on 6/10/2025 at 3:55 PM, LPN E entered Resident #221's room, disconnected Resident #221's Cefepime 1 gram from the left upper arm PICC line and flushed the PICC line with normal saline. LPN E wore gloves to manage Resident #221's PICC line and did not wear a gown. There was a sign on the outside of Resident #221's door that read EBP and there was a PPE container on the back of the door with gown and gloves. During an interview on 6/10/2025 at 4:00 PM, LPN E confirmed Resident #221 had a PICC line, was on EBP and required a gown and gloves for management of the PICC line and stated .I forgot my gown . Review of the medical record revealed Resident #32 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Dementia and Fracture of Left Ulna (long bone in the forearm). Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #32 scored a 7 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Further review revealed the resident required touching assistance with personal hygiene. Review of the comprehensive care plan for Resident #32 revised 5/15/2025, revealed .limited ability to perform self-care tasks . During an observation on 6/9/2025 at 11:52 AM, in Resident #32's room, revealed Certified Nursing Assistant (CNA) A brought Resident #32's tray into the room and placed the meal tray in front of her. CNA A opened the plate warming dome from the plate of food. Resident #32 picked up her fork and began eating the meal. Continued observation revealed CNA A failed to offer Resident #32 hand hygiene assistance prior to the resident eating the lunch meal. During an interview on 6/9/2025 at 11:53 AM, Resident #32's husband stated the staff did not offer hand hygiene assistance to Resident #32 prior to the lunch service. During an interview on 6/9/2025 at 11:56 AM, CNA A confirmed he failed to offer hand hygiene to Resident #32 prior to serving the lunch meal. Review of the medical record revealed Resident #89 was admitted to the facility on [DATE] with diagnoses of Muscle Wasting, Adult Failure to Thrive and Primary Osteoarthritis of the Right Hand. Review of an annual MDS assessment dated [DATE], revealed Resident #89 scored a 11 on the BIMS assessment which indicated the resident had moderate cogntive impairment. Further review revealed the resident required partial or moderate assistance with personal hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the comprehensive care plan for Resident #89 revised 6/5/2025, revealed .limited ability to perform self-care .assist with ADLs [activities of daily living] . During an observation on 6/9/2025 at 11:32 AM, in Resident #89's room, CNA G brought Resident #89's tray into the room and placed the meal tray in front of her. CNA G unwrapped the resident's silverware, opened the plate warming dome from the plate of food, and the resident began eating the meal. Continued observation revealed CNA G failed to offer hand hygiene assistance prior to Resident #89 eating the lunch meal. During an interview on 6/9/2025 at 11:39 AM, Resident #89 stated the staff did not offer hand hygiene assistance prior to the lunch service During an interview on 6/9/2025 at 11:44 AM, CNA G confirmed she failed to offer hand hygiene to Resident #89 prior to serving the lunch meal. Review of the medical record revealed Resident #62 was admitted to the facility on [DATE] with diagnoses of Polyneuropathy, Muscle Wasting and Chronic Kidney Disease. Review of a quarterly MDS assessment dated [DATE], revealed Resident #62 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact. Further review revealed the resident was independent with personal hygiene. Review of the comprehensive care plan for Resident #62 revised 5/2/2025 revealed .potential for ADL decline related to impaired mobility .assist with dressing, bathing, and hygiene . During an observation on 6/9/2025 at 11:40 AM, in Resident #62's room, CNA F brought Resident #62's tray into the room and placed the meal tray on the bedside table in front of her. Further observation revealed the resident opened her flatware, removed the dome from the plate, and began to eat. Continued observation revealed the CNA did not offer hand hygiene assistance or encourage the resident to sanitize her hands prior to eating the lunch meal. During an interview on 6/9/2025 at 11:45 AM, Resident #62 stated the CNA did not offer hand hygiene assistance prior to the lunch meal. During an interview on 6/9/2025 at 11:57 AM, CNA F confirmed she failed to encourage hand hygiene or offer hand hygiene assistance to Resident #62 prior to the lunch meal. During an interview on 6/9/2025 at 1:20 PM, the Director of Nursing (DON) stated the staff were to offer hand hygiene assistance to all residents before meal service. The DON confirmed infection prevention and control practices were not maintained on 6/9/2025 when the staff failed to offer hand hygiene assistance to Resident #32, Resident #89, and Resident #62 prior to the lunch meal service.