STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515159	A. Building B. Wing	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Pointe Healthcare Center	1600 27th Street Parkersburg, WV 26101

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and staff interview, the facility failed to provide the required Notice of Medicare Non-Coverage (NOMNC) form to one (1) of three (3) residents reviewed for the facility's beneficiary protection notification practice during an annual survey. This failure placed residents at risk of not being informed of their rights prior to the end of Medicare Part A covered services. Resident identifier: #371. Facility census: 108.Findings Included:a) Resident #371A facility record review revealed the following details: -Resident #371 was discharged following the end of their Medicare Part A Skilled -On the Minimum Data Set (MDS) Discharge assessment for Resident #371, with an Assessment Reference Date (ARD) of May 22, 2025, Section A (Identification Information) was marked Planned.-There was no evidence that a NOMNC had been issued to the resident prior skilled services ending. During an interview on 07/01/25 at 12:42 PM, the Social Worker Designee #82 verified the NOMNC was not given to Resident #371 or their representative.

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, resident interview, and staff interview, the facility failed to ensure that residents could exercise their right to file a grievance, including the right to file an anonymous grievance. This was a random opportunity for discovery. Facility Census: 108 Findings Included: a) Grievance During an observation on 07/02/25 at 12:04 PM, it was noted that grievance forms were not readily available to residents. Further investigation revealed that grievance forms were kept at the nurses' station. During an interview with Resident #83, the resident stated that she was aware of the grievance policy. Upon being asked how a grievance could be filed, the resident stated that she would ask a staff member for a grievance form. Resident stated that once completed, the grievance form could be dropped off at the Social Worker's office. During an interview with the Director of Social Services (DSS) #76, the facility's designated grievance officer, she stated that if it was a family grievance, they would usually come to her. However, if a resident had a grievance, she stated that the resident would either come to speak to her or file a written grievance and drop it off in the box outside her office. Upon being asked where a resident could obtain a grievance form, DSS #76 stated that the forms were available at the nurses' station on each hallway. During an interview with the Administrator and Regional Director of Clinical Operations (RDCO) #157, on 07/02/25 at approximately 12:20 PM, they confirmed that the grievance forms were not readily available and could not be filed anonymously.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on interview, observation and record review, the Facility failed to ensure that resident was free from physical restraints that unnecessarily inhibited resident's freedom of movement or activity. Resident Identifier: #4. Facility Census: 108 Findings Included: a) Resident #4 During an interview on 07/01/25, at approximately 9:30 AM, the resident stated that she was not allowed to use her wheelchair. Resident #4 indicated a wheelchair parked near her bed and said, That is my wheelchair, and I don't know why they won't allow me to use it. The resident also mentioned that she used to move around in her chair before coming to the facility. The resident mentioned that the facility would not allow her to use her wheelchair, so she requested an alternative chair. She stated that the Director of Physical Therapy (#155) provided her with another chair. The resident pointed to a Broda chair in the room and said, I can't move that chair because my feet don't work. The resident expressed the importance of being able to move in her wheelchair using her arms, as she is unable to stand or use her lower limbs. She mentioned that she has been at the facility for just over a year and, during that time, she has had to either stay in bed or sit in the Broda chair. Resident's spouse, who shares the room with her, said, She is fine and can use her arms to move a wheelchair. I don't understand why they won't let her! A review of Resident #4's records revealed the following physician's orders: - A 02/27/2025 order directed, Resident is medically unable to go on therapeutic outings r/t impaired mobility/contractures. -A 03/6/2024 order directed, May go out on pass with or without meds. -A 07/31/2024 order directed, OK to keep home wheelchair (with) cushion and leg rests in room. -A 07/31/2024 order directed, Mechanical lift for transfers. May leave yellow sling under resident when OOB (out of bed) due to repositioning difficulty and comfort. - A 06/25/2024 order directed, Broda chair with dycem above and below cushion, with footboard. A record review, completed on 07/01/25 at 11:25 AM, revealed the results of a Functional Assessment, dated 04/24/2025, which stated Resident #4 was totally dependent on two (2) helpers in order to transfer from bed to chair or from chair to bed. During an interview with DPT #155, on 07/01/25 at 12:45 PM, he provided the following details of Resident #4's occupational therapy (OT) for the period 08/26/24 to 09/06/24. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The treatment objective was for the resident to achieve her previous level of functioning (PLOF) -Patient's goal: Get this going again. -Assessment noted that the resident stated that she wants to be able to propel a wheelchair regardless of how much time she spends out of bed (OOB) monthly Further review of the provided occupational therapy documentation revealed the following: A note dated 08/28/24 which stated, Worked on a positioning in a standard wheelchair with resident sliding out of wheelchair times two within 20 minutes of being up in chair. Educated on the benefits of continuing to use Broda chair for safety while out of bed with focus on setting resident up with appropriate setting device upon discharge of therapy. Resident worked on wheelchair mobility with SBA (standby-by assist) with sliding out during tasks with focus on increasing independence within facility upon discharge of therapy. A note dated 08/29/24 which stated, Pt (patient) educated in the importance of sitting upright in a chair system in order to play bingo (pt likes this activity). To go out of her room such as sit on the porch to enjoy some fresh air/sunshine. Pt educated that the w/c tried yesterday pt was sliding off and hence unsafe. Pt educated in importance of Broda midline w/s Broda pedal. Pt agreeable to sit in Broda pedal. Pt hoyer lifted by CNA (nurse aide) from bed to Broda pedal. Pt sat in Broda pedal w/c chair positioning system for 2+ hours today. Pt seated upright with both feet not touching the floor at this time. Pt unable to use feet at this time to self propel with her feet. Pt alert, cooperative and agreeable to participate in skilled OT services today. Another note dated 09/06/24 stated, Pt (patient) unable to get OOB (out of bed) for OT tx (treatment) this date d/t (due to) weakness/illness. Mx (multiple) trials of a pedal Broda chair were incorporated into pt's prior OT tx sessions when she was of good health. W/c (wheelchair) seating system updated this date to a Pedal Broda chair with Midline Broda chair being d/c'd (discontinued) per pt's request. Assessed pt's knowledge of the pedal chair and it's features. Pt able to recall mx features and their benefit. Staff education on seating system change this date and aware of need for chair adjustment for pt when OOB. A further interview with DPT #155 on 07/02/25, at 1:15 PM, revealed that subsequent evaluations indicated Resident #4 was unable to use her feet to move her Broda chair. DPT #155 assessed the resident for a Broda chair with larger wheels that she could propel using her arms. He stated that around February 2025, he submitted a requisition for this chair, which would enable the resident to move independently throughout the facility. However, DPT #155 noted that he had not yet received authorization to procure the Broda chair. During an interview with the Administrator on 07/01/25 at approximately 1:30 PM, the Administrator stated that he would check on the status of the requisition. At approximately 10:40 AM on 07/02/25, the Regional Director of Operations (RDO) submitted a copy of a sales quote. He stated that the facility had approved the purchase of the Broda chair. A review of the sales quote revealed that the quote had been requested by DPT #155 on 02/04/25. The sales quote stated, A SIGNATURE AT THE BOTTOM WILL INDICATE ACCEPTANCE OF THIS QUOTE. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quote had been signed and approved on 07/02/25 by the Administrator. During a walk-through of the 300 Hallway, on 07/02/25 at approximately 11:35 AM, Resident #4 was observed sitting in a Broda chair. Resident immediately stated, Did you hear? I am getting that chair! Resident #4 further stated that she had been told that she would have to sit in the chair for at least two hours. She stated, I'll sit here for four hours if necessary! The resident's husband appeared very pleased and stated, Now she will be able to move around and not have to stay in bed all the time! During an interview with DPT #155, he stated that he had received approval to purchase the Broda chair. He stated, Now that I have approval, I want to make sure I get the chair that is suitable for her.

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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. Based on medical record review and staff interview, the facility failed to update the care plan to reflect a change in diet status. This was a random opportunity for discovery. Resident identifier: #82. Facility census: 108. Findings included: a) Inaccurate Care Plan Resident #82's diet order stated, NPO Diet, NPO texture, NPO consistency for Diet type. The resident's care plan stated: 1) Lid on coffee/hot beverage Date initiated: 06/09/2025 2) Staff to offer nutrition/hydration during checks Date initiated 03/07/2023 3) Patient may be fed pureed foods by caregivers or family as snacks are requested Date initiated 07/06/2023 On 07/01/2025 at 02:30 PM, the Director of Nursing confirmed the inaccurate care plan and stated, She hasn't eaten anything. Corporate Registered Nurse #153 stated, We have a care plan problem.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on record review, observation, resident interview, and staff interview, the facility failed to ensure the menus were followed for Residents #64 and Resident #2. This was a random opportunity for discovery. This failured practice had the potential to affect more than a limited number of residents. Resident Identifiers: #2 and #64. Facility Census: 108. Findings included: a) Menus On 06/30/25 at 12:45 PM, Resident #2 was served a hot dog on a flat piece of bread with no condiments. The resident tray card stated, ALL BEEF HOT DOG on a BUN - 1 SANDWICH Mustard - 1 PKT. (packet). Nursing Assistant (NA) #22 reported the resident eats a hot dog almost every day. NA #22 confirmed the hot dog was on a piece of sandwich bread and resident was not given a condiment. During an observation of lunch service on 06/30/25 at approximately 1:11 PM, Resident #64 was unhappy with the meal served to him. He stated that he had ordered a hot dog. He received a hot dog placed on a slice of bread and cheese. He asked the person serving him, Where is the hot dog bun? The aide stated that they had run out of hot dog buns. The resident was unhappy that the meal did not meet his expectations. The Assistant Director of Nursing (ADON) who was present stated that she would check to find out why they did not have hot dog buns.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and staff interview, the facility failed to ensure food was served at an appetizing temperature. This was a random opportunity for discovery. This failure had the potential to affect more than a limited number of residents. Facility Census: 108. Findings included: a) Food temperatures On 07/07/2025 at 01:15 PM, a lunch tray was tested by Regional Dietary Manager #151. This test tray was the last tray to be served on D Hall. The trays were on the hall at 01:05 PM. The following temperatures were obtained: -Bruschetta chicken - 125.1 degrees Fahrenheit -Buttered noodles - 112.0 degrees Fahrenheit -Broccoli - 102.9 degrees Fahrenheit The Regional Dietary Manager #151 confirmed the temperatures for the buttered noodles and broccoli were below the standard.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and record review, the facility failed to store food in accordance with professional standards for food service safety. The failed practice had the potential to affect more than a limited number of resident's. Facility Census: 108. Findings included: a) Food Storage The facility's policy and procedure for Food Storage: Dry Foods stated, 6. Storage areas will be neat, arranged for easy identification, and date marked as appropriate. The facility's policy and procedure for Food Storage: Cold Foods stated, 5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. On 06/30/25 at 11:10 AM during the Kitchen Investigation, the following items were found: -Three pitchers of drinks in the dining room, judged to be punch, lemonade and tea were not labeled or dated and not on ice. -No lock on employee refrigerator in the Main Dining Room. -Sysco Dry Milk - opened with no opened date. -Mission Flour Tortillas - opened and no use by date. -Rice Krispies and Corn Flakes - opened, not labeled or dated. -Hamburger Buns - opened with no open or use by date. -Sunbeam sandwich bread - opened with no open or use by date. -Ground Turkey - no open date. -Sliced Deli Ham in a metal container - opened, not sealed and no use by date. -Worcestershire Sauce - used by date 06/14/2025. -BBQ Sauce - opened 06/03/2025 with no use by date. -Italian Dressing - opened 06/2025 with no use by date. -Marzetti [NAME] Slaw Dressing - opened with no use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Croissants with large hole in the corner of the package. The Assistant Dietary Manager confirmed items were to be discarded seven (7) days after opening. Items were confirmed by Regional Dietary Manager #152 and Account Manager. On 06/30/25 at 1:00 PM, the Cottage's (dementia unit) refrigerator/freezer was investigated. Items found included: -Wholesome Farms Vanilla Ice Cream - opened with no use by date. -Electrolit - opened with no open date. -Peanut butter and jelly sandwiches - no use by date for two (2) sandwiches. -Four (4) sandwiches - not labeled and no use by date. -Sandwiches not properly sealed - in a bag with no closure/seal. -Styrofoam container with plastic fork coming out the side with a red substance on the outside of the container - not labeled or dated. The items were confirmed by Nursing Assistant (NA) #22. The NA stated, I will date .seven (7) days right? and Dietary was here this morning. On 07/01/2025 at 9:45 AM, the East Nourishment Pantry was investigated. Items found included: -Farmer Brothers Coffee - opened, not sealed and not dated. -Basket of snacks - no open or use by date - oatmeal cakes, Quaker Chewy Bars - Peanut butter flavor. -Thick It - no use by date on individual packets. -Great Value Vanilla Ice Cream Sandwiches - no use by date. -Toaster Grills - use by date 06/16/25. Licensed Practical Nurse (LPN) #87 confirmed the items at 10:01 AM and stated, I don't know if dietary has the box. - referring to the thickener. On 07/01/25 10:05 AM, the North Nourishment Pantry was investigated. Items found included: -[NAME] Dean Bacon Breakfast Bowl - dated 06/17-06/23. -Ocean Spray CranGrape juice - opened with no use by date. -Smart Balance individual butter packages -9 (nine) - not dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Individual Lay's Classic Chips - opened, not sealed and not dated. -Rice Krispies Treats- two (2) packages - not dated. -Farmer Brothers Coffee - opened and not dated. -Individual packages of Swiss Miss No Sugar Added hot chocolate - not dated. Licensed Practical Nurse (LPN) #73 confirmed the items at 10:15 AM and stated, I'm gonna get all that out. On 07/01/25 at 11:55 AM, food serving and preparation utensils were observed in drawers with handles not facing the same direction. The Assistant Dietary Manager confirmed and stated, yes .same way.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to ensure patient centered rehabilitative services were provided for Resident #82. This was a random opportunity for discovery and had the potential to affect a limited number of residents. Resident Identifier: #82. Facility Census: 108. Findings included: a) Resident #82 Resident #82 had four (4) plus rehospitalizations per the Minimum Data Set (MDS) and was initially admitted on [DATE]. Speech Therapy (ST) had not screened the patient during her facility stay or upon re-admission to the facility for changes in condition following a hospitalization. The Director of Rehabilitation Services (DOR) stated, Occupational Therapy (OT) and Physical Therapy (PT) usually come from the hospital with orders and the ST need identified by nursing or other therapies. The DOR stated he didn't have speech in the building for awhile. However, interdisciplinary screens had been completed with no ST recommendations by PT and OT. The facility's screening policy and procedure stated, screens should be completed for the following reason: Admission/ re-admission for any discipline not ordered and A screen is used to identify if a change has occurred with a patient. The change may be an improvement, a decline, or a risk that something may happen without therapy intervention. A ST evaluation was completed on 06/20/2023. A ST discharge was completed on 08/03/2023. NPO (nothing by mouth) recommended. Patient to remain NPO but it has been discussed with staff and family re: pleasure feeding. Recommend small bites/sips, sitting upright during PO trials, alternate food/liquid, and ensure bolus is fully consumed before presenting another bolus. A Flexible Endoscopic Evaluation of Swallowing (FEES) or Modified Barium Swallow Study (MBSS) were not indicated on the ST evaluation. On 07/01/25 at 01:15 PM, the Interim Director of Nursing reported there were no instrumental studies (FEES or MBSS) completed for Resident #82 at the hospital or at the facility. Resident #82's diet order stated, NPO Diet NPO texture, NPO consistency for Diet type. The resident's care plan stated: -Lid on coffee/hot beverage Date initiated: 06/09/2025 -Staff to offer nutrition/hydration during checks Date initiated 03/07/2023 -Patient may be fed pureed foods by caregivers or family as snacks are requested Date initiated 07/06/2023 (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's current NPO order reflects a change in condition from the care plan which documents PO intake with pureed food and no liquid consistency indicated. Discharge from 08/03/2023 recommended: alternate food/liquid. On 07/01/2025 at 02:30 PM, the Director of Nursing confirmed the inaccurate care plan and stated, She hasn't eaten anything.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interview, the facility failed to ensure that the medical record was complete for a Physician Orders for Scope of Treatment (POST) form with no signature for Resident #87. This failed practice was true for one (1) of 28 residents reviewed in the Long-Term Care Survey Process. Resident Identifier: #87. Facility Census: 108. Findings included: a) Resident #87 On 06/30/25 at 09:02 PM, Resident #87's POST form was reviewed by the state surveyor. Verbal Consent was given on 04/16/2025 by the resident's legal representative, however a signed consent was not obtained by the facility. There was no evidence in the medical record to reveal the facility had attempted to follow-up with resident's legal representative to obtain a written signature. On 07/01/2025 at approximately 11:35 AM, the Interim Director of Nursing stated that they were mailing out the POST form today to be signed.

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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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on facility record review and interview, the facility failed to explain the Binding Arbitration Agreement accurately and in a form and manner residents or Resident Representatives could understand. This had the potential to affect all residents or Residents Representatives that sign a Binding Arbitration Agreement. Facility Censes: 108. Findings included: a) Binding Arbitration Agreement A facility record review of the found 81 Residents or Resident Representatives signed and accepted the Binding Arbitration Agreement. 15 Residents or Residents Representatives signed and declined the Binding Arbitration Agreement. During an interview, on 07/01/25 at 1:18 PM, the Back-Up admission Coordinator was unable to explain the Binding Arbitration Agreement accurately. She stated that she was unsure who chose the Arbitrators and that the Resident or Representatives could take their issues to a court of law if they did not like the outcome of the Arbitration. When the admission Coordinator was asked questions about the Binding Arbitration Agreement, she was unable to explain. The admission Coordinator at this time stated that Residents don't usually ask questions about the form. She stated that she would need to better familiarize herself with the Agreement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515159	A. Building B. Wing	07/08/2025

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on facility documentation, staff interview and Operation Policy, the facility failed to have a certified Infection Preventionist (IP) attend and participate in the Quality Assessment and Assurance (QAA) meetings that worked at least part time in the facility and have all members attend, This failed practice had the potential to affect all residents residing at the facility. Facility Census: 108. Findings included: Record review of the facility's policy titled, QAPI Quality Assurance performance Improvement Plan (QAPI), with effective date 10/01/2017, found: - The QAPI committee will include the: Executive Director, Director of Nursing, Medical Director, Infection Preventionist, three other staff members and other state required attendees. -Monthly the QAPI committee will meet with all members of the committee present and review any open performance improvement plans, facility audits, or data collected since the last meeting. a) QAA Record review of the facility's documentation of QAA Meeting Agenda and Minutes revealed no IP attended the meeting from the October 2024 - December 2024 quarter. -Meeting on 10/11/24, four members attended, the Executive Director, Director of Nursing, Medical Director and one other member. The DON signed both DON and Infection preventionist (IP) -Meeting on 11/08/24, four members attended, the Executive Director, Director of Nursing, Medical Director and one other member. The DON signed both DON and Infection preventionist (IP) -Meeting on 12/13/24, four members attended, the Executive Director, Director of Nursing, Medical Director and one other member. The DON signed both DON and Infection preventionist (IP) During an Interview 07/08/24 at 10:38 AM, the Executive Director verified the facility could not produce evidence the DON was officially certified as an IP and had been working in that role byond her 40 hours a week as the facility's DON. The Executive Director verified all required members did not attend the QAPI meetings. No other information was provided prior to the end of the survey on 07/08/25.

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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 interviews, observations, and record reviews, the facility failed to ensure that staff adhered to infection control protocols while caring for residents classified as requiring Enhanced Barrier Precautions (EBP). Staff failed to wear Personal Protective Equipment (PPE) as specified by the EBP guidelines posted outside the resident's room. This was a random opportunity for discovery. Resident Identifier: #105. Facility Census: 108. Findings Included: a) Resident #105 During an interview on 07/01/25 at approximately 9:40 AM, the resident stated that she had a Foley catheter. Resident was alert, oriented, and had a Brief Interview for Mental Status (BIMS) score of 8. She stated that she had the catheter because she did not have control of her bladder. The resident was under Enhanced [NAME] Precautions, and the notice posted outside Resident #105's room stated the following: ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: -Clean their hands, including before entering and when leaving the room PROVIDERS AND STAFF MUST ALSO: -Wear gloves and a gown for the following High-Contact Resident 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. Wound Care: any skin opening requiring a dressing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the physician's orders revealed the following, Foley cath care every shift and PRN (as needed) with soap and water. Secure straps if applicable, document output every shift. Provide anchoring device, privacy bag, and position privacy bag correctly. During an observation of catheter care on 07/07/25 at approximately 2:45 PM, Licensed Practical Nurse (LPN) #90 and Nursing Assistant (NA) #107 performed catheter care on Resident #105. LPN #90 and NA #107 entered the resident's room, donned gloves, but did not don gowns. They pulled the curtains around the resident's bed, and then proceeded to lower the resident's bed. LPN #90 then assisted NA #107 to roll the resident so that her brief could be removed. NA #107 then brought in soap and water and towels and began to clean the resident's perineum, discarding the soiled towels into a soiled linen bag prepared for the purpose. NA #107 then began to clean the catheter, starting from the point nearest to the meatus and wiping, moving away. All soiled towels were discarded into the soiled linen bag. Once the catheter had been cleaned, they informed the resident that they would be putting a clean brief on her. LPN #90 and NA #107 then proceeded to put a clean brief on the resident, still without changing gloves or donning a gown. Upon completion of the care, they pulled the resident up in bed and made her comfortable. They removed the soiled linen bag from the room. Unit Manager (UM) #64 was notified of the failure to follow EBP protocols on 07/07/25 at approximately 3:00 PM. UM #64 confirmed that EBP protocols required that the specified Personal Protective Equipment (PPE) should be donned before care was provided to residents. UM #64 stated that she would begin education and training immediately.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, the facility failed to maintain bed remote controls in a safe operating condition. This is true for one (1) of five (5) resident beds reviewed. Facility census:108. Findings included: a) room [ROOM NUMBER]B During an interview on 07/01/25 at approximately 2:55 PM, Employee #32. was asked if they were aware of any issues with any exposed electrical wiring. The employee replied, You mean like bed remotes? Yes. One is located in room [ROOM NUMBER]B. On 07/01/25 at approximately 3:10 PM, Surveyor observed electrical tape on the bed control remote on resident bed 123B. On 07/02/25 at approximately 7:53 AM, an interview with the facility Maintenance Director verified that the bed control remote for bed 123 B had electrical tape on the remote. This finding was also acknowledged by the Administrator upon exit on 07/08/25 at approximately 1:00 PM.