

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Cabell Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 30 Hidden Brook Way Culloden, WV 25510	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and staff interviews the facility failed to develop care plans for Post-Traumatic Stress Disorder (PTSD) and diuretic therapy. Additionally, the facility failed to implement a designated fall intervention requiring a reacher tool to be within the resident's reach. This deficient practice was found true for (3) three of 25 residents reviewed for care plan accuracy during the Long-Term Care Survey Process. Resident identifiers: #2, #67, and #7. Facility Census: 88 Findings Include: a) Resident #67 A record review conducted on 07/16/26 at 10:00 AM, revealed a fall intervention care plan for Resident #67. The documented interventions included: Provide assistive devices as needed Perimeter mattress Wheelchair cushion reviewed reaching device non skid material applied to wheelchair An observation of Resident #67's room on 07/16/26 at 11:10 AM, revealed the resident was not in the room, and no reaching device was located in the room. Further observation of Resident #67 in the Lighthouse dining area revealed that the resident did not have the reaching device in their possession. During an observation and interview on 07/16/26 at 11:16 AM, Registered Nurse (RN) #26 located the reaching device at the bottom of Resident #67's closet. RN #26 stated, It does not look like she is using it. I am not even sure that she is capable of using it. I will check into it. b) Resident #2 (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review conducted on 07/14/26 revealed that Resident #2 had an active diagnosis of Post-Traumatic Stress Disorder (PTSD). Further review of the record revealed that Resident #2's care plan failed to include the diagnosis of PTSD or any corresponding interventions. During an interview on 07/16/26 at 10:07 AM, the Director of Social Services confirmed that PTSD was not addressed in Resident #2's care plan and stated, I will fix that, yes it should be care planned. c) Resident #7 Review of Resident #7's physicians' orders showed an order written on 03/18/26 for furosemide 40 mg twice a day for hypertension. Furosemide (Lasix) is a diuretic. Review of Resident #7's comprehensive care plan showed the following focus initiated on 12/10/24, The resident is at risk for dehydration, or potential fluid deficit, hx [history] of IV [intravenous] fluid administration. The focus had not been revised. The goal initiated on 12/10/24 was as follows: Resident will be free of s/sx [signs and symptoms] of dehydration, such as dry chapped lips, tongue dryness, sunken eyes, decreased absent, or concentrated urine output, poor skin elasticity, though review date. The interventions were as follows: Encourage resident to drink all liquids on meal tray, and provide extra fluids on nourishment pass and during social gatherings and activities. Notify medical provider with s/sx of dehydration. Obtain labs per medical providers order. Resident #7's care plan did not contain a focus or interventions related to diuretic use. On 07/20/26 at 3:21 PM, the Director of Nursing confirmed Resident #7's care plan did not contain a focus or interventions related to diuretic use. No further information was provided through the completion of the survey process.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, record review, and staff interview, the facility failed to follow physician's orders. This deficient practice had the potential to affect (three) of 25 residents reviewed in the long-term care survey sample. Resident Identifiers: #3, #5, and #9. Facility Census: 88. Findings included: a) Resident #3 Review of Resident #3's physician's orders showed an order written on 4/7/26 for Accucheck fingerstick blood glucose monitoring. The physician was to be notified if the blood glucose level was less than 60 or greater than 400. The Accucheck fingerstick blood glucose monitoring was scheduled for early morning and evening. On the Medication Administration Record (MAR) for July 2026, the entry for the early morning blood glucose monitoring had two (2) lines, one for the nurse to enter the blood glucose level and one (1) for the nurse's user identification. The entry for the evening blood glucose monitoring did not have a line for the nurse to enter the blood glucose level. There was only one (1) line for the nurse's user identification. Sometimes, the evening blood glucose level was recorded on the blood sugar tab summary located in the weights and vitals section of the electronic health record. However, for the following dates, the evening blood sugar was not recorded in July 2026:07/03/2607/04/2607/05/2607/07/2607/08/2607/09/2607/10/2607/13/2607/14/2607/15/2026 at 10:40, the Assistant Director of Nursing (ADON) confirmed that Resident #3's evening glucose level had not been documented on the above-referenced dates. She stated another line had been added to the MAR so the results could be recorded. No further information was provided through the completion of the survey process. b) Resident #5 Review of Resident #5's physician's orders showed an order written on 06/03/26 for Novolog insulin, inject five (5) units subcutaneously before meals and at bedtime for diabetes, if the resident's blood sugar level was greater than 150. Review of Resident #5's Medication Administration Record (MAR) for June and July 2026 showed Resident #5 had been administered insulin, despite the blood glucose level being less than 150, on the following dates and times: 06/05/26 at 11:00 AM; the blood glucose level was 12306/06/26 at 11:00 AM; the blood glucose level was 13706/14/26 at 5:00 PM; the blood glucose level was 13406/14/26 at 9:00 PM; the blood glucose level was 14706/15/26 at 11:00 AM; the blood glucose level was 13907/10/26 at 11:00 AM; the blood glucose level was 14707/16/2026 at 11:32 AM, the Director of Nursing (DON) confirmed that Resident #5's insulin was signed on the MAR as given despite the resident's blood glucose being less than 150. The DON stated she cannot prove that Resident #5's insulin was not given on those occasions. No further information was provided through the completion of the survey process. c) Resident #9 Review of Resident #9's physician's orders showed an order written on 08/08/25 for a right hand orthotic (carrot splint) to be worn, as tolerated, every day and night shift for contracture of the right hand. A carrot splint is a carrot-shaped splint placed in a contracted hand to prevent skin breakdown of the palm. Upon initial observation of Resident #9 on 07/13/26 at 2:30 PM, the resident did not have the carrot splint placed in her right hand. Upon observation on 07/15/2026 at 10:49 AM, the resident did not have the carrot splint placed in her right hand. Upon observation on 07/16/2026 at 09:11 AM, the resident did not have the carrot splint placed in her right hand. Review of Resident #9's Treatment Administration Record (TAR) showed the carrot splint had been signed off as being in place twice daily in July 2026. On 07/16/26 at 2:07 PM, the Assistant Director of Nursing (ADON) examined Resident #9's right palm skin condition in the presence of the surveyor. The resident's palm skin condition was clean and intact. The ADON confirmed Resident #9's carrot splint was not in place. She stated she would look for the splint. On 07/16/26 at 2:27 PM, the ADON stated she had placed the resident's carrot splint in her right hand after locating the splint in (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident's room. On 07/20/2026 at 11:14 AM, Resident #9 was noted to have the carrot splint in her right hand. She appeared to be tolerating the splint well.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, record review, staff interview and resident interview, the facility failed ensure a complete and accurate medical record for a resident by documenting blood pressures being taken in opposite arm. for a resident with an incomplete capacity form, additionally, a resident's TAR being completed for a device she no longer wore and lastly for a resident with an incorrect capacity form. This included Resident's #3, #62, #35 and #46. Facility Census 88. Findings included: a) Resident #3 - Blood Pressure -Upon review of resident's Weights and Vitals Summary on 07/15/26, it was document that resident's blood pressure was obtained in the left arm on the following dates in the last 90 days: 05/29/26 05/27/26 05/26/26 -Review of current ordered stated, Do not obtain blood pressures, lab draws, IV access sites to left arm due to AV fistula in left arm. Order date 06/19/25 -Resident had capacity to make her own health care decisions. Interview with resident on 07/15/26 at 3:15 PM who reported staff do not attempt to obtain her blood pressure in her left arm. -Interview with Administrator on 07/15/26 at 3:50 PM who acknowledge the documentation for the left arm. b) Resident #62 - Capacity incomplete -Review of resident's form Physician's Determination of Capacity dated for 02/25/26 was incomplete. The first boxes read as follows and neither box was checked: *Demonstrates CAPACITY to make decisions *Demonstrates INCAPACITY to make medical decisions etc. -Interview with Administrator on 07/15/26 at 10:00AM who acknowledge the incomplete document. c) Resident #46 Review of Resident #46's medical records showed a Physician's Determination of Capacity form dated 03/18/26. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The preprinted form stated, I have interviewed the resident and have determined that he/she: The physician checked a box that stated, Demonstrates capacity to make decisions. However, the physician also checked a box that stated, Per WV code 16-30-7 I certify that have informed the patient that he or she has been determined to be incapacitated and that a medical power of attorney representative or surrogate decisionmaker may be making decisions regarding life prolonging intervention or mental health treatment. On 07/16/2026 at 11:09 AM, the Director of Nursing (DON) confirm Resident #46's Physician's Determination of Capacity form was incorrectly completed and gave conflicting information. The DON stated Resident #46 does have capacity to make medical decisions. No further information was provided through the completion of the survey process. d) Resident #35 Review of Resident #35's physician's orders showed an order written on 04/28/26 for Device: Left hinged knee brace locked in extension every day and night shift. The resident's Treatment Administration Record (TAR) for July 2026 showed the left hinged knee brace had been signed off twice a day as present. On 07/13/2026 at 12:06 PM, Resident #35 stated she fell out of her wheelchair and hurt her left knee several months ago. She stated she was receiving therapy and her knee was doing better. At the time of this interview, Resident #35 was not wearing a knee brace. Another observation on 07/15/26 at 12:37 PM showed Resident #35 was not wearing a knee brace. On and 07/16/26 at 12:32 PM, Resident #35 was again observed not wearing a knee brace. When questioned, the resident stated that she hadn't worn that brace in a long time because her orthopedic doctor discontinued it. On 07/16/2026 at 12:50 PM, Licensed Practical Nurse (LPN) #98 stated he didn't know anything about Resident #35's knee brace. On 07/16/26 at 12:54 PM, the Director of Nursing (DON) confirmed Resident #35 was not wearing a knee brace. On 07/16/2026 at 1:10 PM, the DON stated she talked with the orthopedic surgeon's office and the resident doesn't need the knee brace anymore. She acknowledged the TAR was signed out for a device the resident was no longer wearing. No further information was provided through the completion of the survey process.		

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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. Based on observation, record review, and staff interview, the facility failed to ensure residents with indwelling urinary catheters had their urine collection bags concealed with a privacy cover to maintain resident dignity. This deficient practice had the potential to affect two (2) of three (3) residents reviewed for the care area of catheters. Resident Identifiers: #82 and #93. Facility Census: 88. Findings included: a) Resident #93 Review of Resident #93's physician's orders showed an order written on 07/10/26 for Indwelling Urinary (Foley) Catheter: #16 F [French] with 10 ml [milliliter] balloon to continuous drain. Diagnosis for use urinary retention. Provide privacy bag. Upon observation 07/13/2026 at 12:25 PM, Resident #93's indwelling urinary catheter collection bag was hanging on the side of the bed facing the door. The urine collection bag did not have a privacy cover, and urine could be seen in the bag. Upon observation on 07/14/2026 at 9:34 AM, the urine collection bag continued to not have a privacy cover. On 07/14/2026 at 1:25 PM, the Infection Preventionist confirmed Resident #93's urine collection bag did not have a privacy cover. She stated she would obtain a privacy cover.No further information was provided through the completion of the survey process. b) Resident #82Review of Resident #82's physician's orders showed an order written on 03/10/25 for suprapubic cath [catheter] #18 fr [French] with 6 ml balloon to continuous drain. Diagnosis for use: neurogenic bladder. Provide privacy bag.Upon observation on 07/13/2026 at 3:08 PM, Resident #82's suprapubic catheter urine collection bag did not have a privacy cover, and urine could be seen in the bag. Upon observation on 07/14/2026 at 9:54 AM, Resident #82's urine collection bag continued to not have a privacy cover. On 07/14/2026 at 1:25 PM, the Infection Preventionist confirmed Resident #82's urine collection bag did not have a privacy cover. She stated she would obtain a privacy cover.No further information was provided through the completion of the survey process.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to document that required information was conveyed to the receiving hospital at the time of the resident's transfer. This deficient practice had the potential to affect one (1) of five (5) residents reviewed for the care area of hospitalization. Resident Identifier: #46. Facility Census: 88. Findings included: a) Resident #46 Review of the facility's policy titled, Transfer and Discharge Policy, with no implementation date given, stated a transfer form would be sent with the resident or as soon as practicable in the event of an emergency transfer. The transfer form would document as follows: Patient status, including baseline and current mental, behavioral and functional status and recent vital signs;Current diagnoses, allergies and reasons for transfer/discharge;Contact information of the practitioner responsible for the care of the resident;Patient representative information and contact information; Current medications, treatments, relevant lab and/or radiological findings and recent immunizations;Special instructions such as isolation precautionsSpecial risks such as risk for falls, elopement, bleeding, pressure injury, or aspirationComprehensive care plan goals Review of Resident #46's electronic health record showed the resident was transferred to the hospital on [DATE] due to abdominal pain. No transfer form was located in the health record. On 07/20/26 at 11:48 AM, the Director of Nursing confirmed that a transfer form had not been sent to the receiving hospital when Resident #46 was transferred on 04/03/26. She stated there was no documentation to show required information had been conveyed to the receiving hospital. No further information was provided through the completion of the survey process.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, record review, and staff interview, the facility failed to ensure complete and accurate Minimum Data Set (MDS) assessment in the area of catheters. This deficient practice had the potential to affect (1) of three (3) residents reviewed for the care area of catheters. Resident Identifier: #82. Facility Census: 88. Findings included:a) Resident #82Review of Resident #82's physician's orders showed an order written on 03/10/25 for suprapubic cath [catheter] #18 fr [French] with 6 ml balloon to continuous drain. Diagnosis for use: neurogenic bladder. Provide privacy bag.On 07/13/2026 at 3:08 PM, Resident #82 was observed to have a suprapubic catheter urine collection bag.Resident #82's quarterly Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 06/02/26 indicated that Resident #82 did not have an indwelling urinary catheter.On 07/14/26 at 2:45 PM, MDS Registered Nurse #50 confirmed Resident #82's MDS with ARD 06/02/26 was incorrect and should have indicated the resident had an indwelling urinary catheter.No further information was provided through the completion of the survey process.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on record review, observation, resident interview and staff interview the facility failed to ensure a resident with limited range of motion received appropriate treatment to prevent further decrease in range of motion. This failed practice was found true for (1) one of (3) three residents reviewed for the care area of limited range of motion during the Long-Term Care Survey Process. Resident identifier: #64. Facility Census: 88. Findings include: a) Resident #64 During the initial interview on 07/13/26 at 1:59 PM, Resident #64 stated, I am supposed to wear a brace on my left hand, but it went to laundry a while back and I haven't seen it since. When asked by the State Agency (SA) if the splint was worn often, Resident #64 replied, I do, when I have it. I like to wear it at night when I am sleeping. A record review on 07/14/26 revealed Resident #64 has a diagnosis of Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the left non-dominant side. Further record review identified an active physician's order for Resident #64 dated 02/26/26, which read: Device: Patient to wear resident hand splint to L extremity as tolerated. A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) from February 2026 to the present revealed that this order was missing from both records. On 07/14/26 at 1:48 PM, Resident #64 was observed in her bathroom preparing for the day. The hand brace was not on the resident; instead, it was lying in a basket in the bathroom. Resident #64 stated, I came in the bathroom last night and it was lying in here. I wore it last night. I guess laundry brought it back. No, no one has offered to put it on today. During an interview on 07/14/26 at 2:53 PM, Registered Nurse (RN) #26 stated, I went and talked to her, and she said that she wore the brace last night and she just put it back on. I have now updated the order, it will show up on the TAR, so that we have accountability that she is wearing the brace.		

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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. Based on observation and staff interview, the facility failed to ensure the facility was as free from accident hazards as possible. A treatment cart was unlocked with no staff in attendance. This was a random opportunity for discovery that had the potential to affect more than a limited number of residents. Facility Census: 88. Findings included: a) Treatment cart On 07/14/2026 at 9:39 AM, a treatment cart located in the 200 hallway was noted to be unlocked. No staff were in attendance by the cart or in the hallway. On 07/14/26 at 9:41 AM, the surveyor alerted Registered Nurse (RN) #17 that the treatment cart was unlocked. She confirmed the cart was unlocked and should be locked when staff were not in attendance. The cart was inspected and a drawer contained cleansers and creams used in wound care. RN #17 confirmed these cleansers and creams could be hazardous to residents. On 07/15/26 at 3:00 PM, the Assistant Director of Nursing (ADON) stated the facility had no written policy regarding locking the treatment cart. No further information was provided through the completion of the survey process.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, record review, and staff interview, the facility failed to ensure catheter treatment and care was provided within accepted standards of practice. For one (1) of three (3) residents reviewed for the care area of catheters, the urinary collection bag was on the floor. Resident Identifiers: #82. Facility Census: 88. Findings included:a) Resident #82 The facility's policy titled, Catheter Care, with no implementation date given, gave instructions to check that the collection bag was not on the floor. Upon observation on 07/13/26 at 3:08 PM, Resident #82's suprapubic catheter urine collection bag was noted to be lying on the floor of the resident's room.Upon observation on 07/14/26 at 9:54 AM, Resident #82's urine collection bag continued to be lying on the floor.On 07/14/2026 at 1:25 PM, the Infection Preventionist confirmed Resident #82's urine collection bag was lying on the floor. She stated she would move the urine collection bag off the floor. No further information was provided through the completion of the survey process.		

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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. Based on observation, record review, and staff interview, the facility failed to ensure an error rate of less than five (5) percent. Two (2) errors were observed in 29 medication administration opportunities to give an error rate of 6.9 percent. This deficient practice had the potential to affect two (2) of three (3) residents reviewed for the care area of medication administration. Resident Identifiers: #14 and #60. Facility Census: 88. Findings included: a) Resident #14 On 07/15/2026 at 8:00 AM, Licensed Practical Nurse (LPN) #77 was observed preparing morning medications for Resident #14. LPN #77 crushed the resident's medications and placed them in applesauce. Among the medications crushed was enteric coated aspirin, 325 milligrams (mg). Aspirin tablets are enteric coated to delay the release of the medication until it reaches the small intestine because it can be irritating to the stomach. On 07/15/2026 at 10:37 AM, LPN #77 was asked if the facility had a list of medications that should not be crushed. She stated she thought the list was in a notebook on the medication cart, but she could not locate it. On 07/15/2026 at 10:40 AM, the Director of Nursing (DON) provided a list from the American Society of Consultant Pharmacists (ASCP) titled, Medications Not to be Crushed, with revision date March 2016. Enteric coated aspirin was on the list of medications not to be crushed. This was confirmed by the DON. No further information was provided through the completion of the survey process. b) Resident #60 On 07/15/2026 at 8:15 AM, Registered Nurse (RN) #17 was observed administering medications to Resident #60. Resident #60 had her breakfast tray. Among the medications administered to Resident #60 was pantoprazole (Protonix). Resident #60's pantoprazole order, written to start on 06/20/24 at 7:00 AM, stated to give the medication for gastroesophageal reflux disease in the morning before breakfast. The medication was timed on the Medication Administration Record (MAR) to be given in the AM. According to the Mayo Clinic drug and supplements information, available on-line, pantoprazole should be taken at least 30 minutes before a meal. On 07/15/2026 at 10:40 AM, the Director of Nursing confirmed Resident #60's pantoprazole was ordered to be given before breakfast. She stated she would ask the physician if the medication needed to be given before breakfast. If so, she stated she would retime the medication on the MAR.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2026
NAME OF PROVIDER OR SUPPLIER Cabell Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 30 Hidden Brook Way Culloden, WV 25510	
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. Based on observation, record review, and staff interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed to ensure a resident in enhanced barrier precautions (EBP) had proper signage to alert staff and others of the EBP. The facility also failed to maintain infection control practices during medication administration. These were random opportunities for discovery. Resident Identifiers: #93 and #60. Facility Census: 88. Findings included:a) Resident #93 The facility's policy titled, Enhanced Barrier Precautions, with no implementation date given, stated signs would be posted on the resident door as communication to staff and visitors to indicate the resident was in enhanced barrier precautions. Review of Resident #93's physician's orders showed an order written on 07/13/26 for Enhanced barrier precautions related to: indwelling foley catheter, when dressing/bathing, showering/transferring in room or therapy gym/personal hygiene, changing linen, providing hygiene, changing briefs or assisting with toileting. On 07/13/26 at 2:00 PM, Resident #93's room did not have signage to indicate the resident was in enhanced barrier precautions. On 07/14/26, Resident #93's physician's order was changed to, Enhanced barrier precautions related to: indwelling foley catheter, PICC [peripherally-inserted central catheter] line to RUE [right upper extremity], R [right] BKA [below the knee amputation] wound When dressing/bathing, showering/transferring in room or therapy gym/personal hygiene, changing linen, providing hygiene, changing briefs or assisting with toileting. On 07/14/26 at 12:30 PM, Resident #93's room did not have signage to indicate the resident was in enhanced barrier precautions. On 07/14/2026 at 1:24 PM, the Infection Preventionist confirmed Resident #93's room did not have signage to indicate the resident was in enhanced barrier precautions. She stated she had revised the resident's enhanced barrier precautions order but hadn't put up a sign yet. No further information was provided through the completion of the survey process. b) Resident #60 The facility's policy titled, Medication Administration, with no implementation date given, stated, Do not touch the medication, either when opening a liquid or dose pack. On 07/15/2026 at 8:15 AM, Registered Nurse (RN) #17 was observed administering medications to Resident #60. While pouring the medications from the medication packet into the medication cup, one medication tablet fell onto the top of the med cart. RN #17 picked up the pill with her bare hands and placed it into the cup. She stated, I shouldn't have touched that. Sorry. On 07/15/2026 at 10:40 AM, the Director of Nursing confirmed the nurse should not have touched the medication tablet with her bare hands. No further information was provided through the completion of the survey process.		