STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165423	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Ames, LLC	3440 Grand Avenue , Ames, Iowa, 50010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 ✓	INITIAL COMMENTS The following deficiencies resulted from the facility's annual recertification survey and investigation of facility reported incident #2748701-I conducted April 13, 2026 to April 16, 2026. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000	**F000** Accura Healthcare of Ames denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains and is in compliance with the requirements of participation, or that corrective actions was necessary.	
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.	F0628	F0628 In continuing compliance with F628, Discharge Process, Accura Healthcare of Ames corrected the deficiency by auditing all resident hospital transfers since 4/16/26 to ensure a Bedhold Notification was completed for Resident #3, Resident #69 and all like residents on 4/30/2026 by the Administrator. To correct the deficiency and to ensure the problem does not recur, all Facility Nurses, Administrator, Business Office Manager, and Social Worker were educated on the expectation that Bedhold Forms are reviewed with residents and/or resident representatives before being transferred to the hospital. This education was provided by 5/8/2026 by the Administrator. The Administrator and/or Designee will audit resident Bedhold Notification Process 2x weekly for 12 weeks and PRN to ensure continued compliance. As part of Accura Healthcare of Ames ongoing commitment to quality assurance, the Administrator and/or Designee will report identified concerns through the community's Quality Assurance Process.	

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 reverse for further 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
[signature]	Administrator	5/8/2026

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F0628 SS = D	Continued from page 1 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written	F0628		

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F0628 SS = D	Continued from page 2 notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the	F0628		

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F0628 SS = D	Continued from page 3 State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (l) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to	F0628		

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F0628 SS = D	Continued from page 4 authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, policy review and staff interview, the facility failed to ensure the resident or representative received written bed hold information prior to a transfer to the hospital for 2 of 2 residents reviewed for hospitalization (Residents #3 and #69). The facility reported a census of 63 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 11/20/25 revealed Resident #3 had a Brief Interview for Metal Status (BIMS) score of 4 indicating severe cognitive impairment. The MDS further revealed the resident had diagnoses including respiratory failure and end stage renal (kidney) disease and received dialysis. Review of Progress Notes for Resident #3 revealed the resident was transferred to the hospital from the dialysis center on 12/24/25 for treatment of low oxygen saturation (tissues not receiving sufficient oxygen). The clinical census for Resident #3 documented a hospitalization 12/24/25-12/29/25. Clinical record review for Resident #3 lacked documentation related to bed hold notification prior to the 12/24/25 hospitalization. 2. The MDS assessment dated 11/13/25 revealed Resident #69 had a BIMS of 13 indicating intact cognition. The MDS further revealed the resident had diagnoses including osteomyelitis and muscle weakness. Review of Progress Notes revealed Resident #69 was transferred and admitted to the hospital on 1/18/26 due to a hip fracture. The clinical census for Resident #69 documented the	F0628		

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F0628 SS = D	Continued from page 5 resident was hospitalized 1/18/26 and billing was stopped 1/20/26. Clinical record review for Resident #69 lacked documentation related to bed hold notification prior to the 1/18/26 hospitalization. Review of facility policy titled, Emergency Notice of Transfer/Discharge, updated 4/4/25 revealed the following: Even though our Facility expects that you will return to our Facility following your hospitalization, federal regulations under 42 C.F.R. §§483.15(c)(3) and (5) require that we provide you with a written notice regarding your transfer to the hospital and your appeal rights. During an interview 4/15/2026 at 2:26 PM the Administrator revealed he was not able to locate information regarding bed hold notification for Resident #3 or #69 with their most recent hospitalizations. During an interview 4/16/2026 at 12:00 PM, the Administrator revealed he would have expected bed hold notifications be presented for Resident #3's and Resident #69's hospitalizations.	F0628		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion	F0641	**F641** In continuing compliance with F641, Accuracy of Assessments, Accura Healthcare of Ames corrected the deficiency by correcting the MDS Assessments for Resident #8, Resident #6, and Resident #62 by 5/5/26. An audit to ensure assessment accuracy for all like residents was completed by 5/8/2026 by the MDS Coordinator. To correct the deficiency and to ensure the problem does not recur, the MDS Coordinator was educated to ensure PASRR status is coded accurately on resident MDS assessments by the DON on 5/5/26. MDS Coordinator was also educated on 5/5/26 by the DON that GLP-1 medications are not considered insulins and should not be coded as such on MDS assessments. The DON and/or Designee will audit resident MDS assessments 2x weekly for 12 weeks and PRN to ensure continued compliance. As part of Accura Healthcare of Ames ongoing commitment to quality assurance, the DON and/or Designee will report identified concerns through the community's Quality Assurance Process.	

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F0641 SS = D	Continued from page 6 of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, policy review, the Food and Drug Administration (FDA), staff, and resident interviews the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 3 of 20 residents reviewed (Residents #6, #8 and #62). The facility reported a census of 63 residents. Findings include: 1. Resident #8's Minimum Data Set (MDS) dated 2/4/26 indicated they didn't have a serious mental illness and/or intellectual disability or related condition. The MDS included diagnoses of anxiety, depression, and bipolar disorder (a mental health condition that causes extreme mood swings). A notice of PASRR Level I screen outcome dated 11/17/25 reflected a positive screening and showed no status change. The PASRR Level I Identification Screen showed Resident #8 had evidence of a serious mental illness or an intellectual or developmental disability (IDD). The screen directed the facility to mark "yes" for question A1500 on the MDS. 2. Resident #6's MDS dated 2/24/26 lacked a diagnosis of diabetes mellitus. It indicated Resident #6 took insulin for 1 of 7 days during the lookback period. The Physician's Orders indicated Resident #6 took 10 milligrams (mg) of Zepbound (tirzepatide) under the skin once a week for weight management.	F0641		

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F0641 SS = D	Continued from page 7 On 4/14/26 at 2:40 PM, Resident #6 denied being diabetic and didn't take insulin. He stated he took a shot of something once a week for weight loss. 3. Resident #62's MDS dated 3/24/26 lacked a diagnosis of diabetes mellitus. The MDS reflected she took insulin 1 of 7 days during the lookback period. The Physician's Orders indicated Resident #62 took 12.5 mg of Zepbound under the skin once a week for weight management. On 4/14/26 at 2:35 PM, Resident #62 denied being diabetic and thought she took the insulin Wegovy once a week for weight loss. On 4/15/26 at 1:27 PM, Staff F, MDS Coordinator, stated she gathered information for the MDS by observing on the floor and talking to residents. When she answered question A1500 she looked at the last PASRR evaluation. If she knew it was marked wrong, she would submit a correction to the MDS which she will do. When she answered the question about insulin injections in the last 7 days on the MDS she looked at the Electronic Medication Administration Record (EMAR). She had several residents getting Wegovy and she marked them as 1 day of insulin, as they count as insulin. If she found out that was incorrect, she would submit an MDS correction. On 4/16/26 at 1:31 PM, the Director of Nursing (DON) stated she didn't know if Zepbound should be coded as an insulin on the MDS. She stated Resident #6 and Resident #62 both took it for weight loss. According to the Food and Drug Administration (FDA), Zepbound is a glucose-dependent insulinotropic polypeptide (GIP) receptor and glucagon-like peptide-1 (GLP-1) receptor agonist (a class of medications used to treat obesity) indicated for chronic weight management. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2025 defined Insulin as a medication used to treat diabetes mellitus. The manual directed staff to code all high-risk drug class medications according to their pharmacological classification, not how they are being used. The Conducting an Accurate Resident Assessment policy updated April 2025 directed that all residents receive an accurate assessment by qualified staff. It	F0641		

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F0641 SS = D	Continued from page 8 instructed the Administrator to ensure all participants have the requisite knowledge to complete an accurate assessment addressing each resident's status and needs.	F0641		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F0656	**F656** In continuing compliance with F656, Develop/Implement Comprehensive Care Plan, Accura Healthcare of Ames corrected the deficiency by updating Resident #17's Care Plan to include his/her desire to smoke and audited all like residents to ensure their Care Plans included the desire to smoke on 4/17/26 by the MDS Coordinator. A complete audit of all resident Care Plans was completed to ensure fall interventions listed are in place for Resident #72 and all like residents by 5/8/26 by the MDS Coordinator. To correct the deficiency and to ensure the problem does not recur, Facility MDS Coordinator was educated by 5/8/26 that a resident's desire to smoke is added to the resident's Care Plan and all Facility Nursing Staff were educated on ensuring Care Plan Interventions are in place at all times. The DON and/or Designee will audit resident care plans to ensure smoking is identified when applicable 2x weekly for 12 weeks and then PRN. The DON and/or Designee will audit to ensure fall interventions are in place 3x weekly x 4 weeks, 2x weekly x 4 weeks, 1x weekly x 4 weeks, and PRN to ensure continued compliance. As part of Accura Healthcare of Ames ongoing commitment to quality assurance, the DON and/or Designee will report identified concerns through the community's Quality Assurance Process.	

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F0656 SS = D	Continued from page 9 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to develop and implement comprehensive care plans accurately reflecting the needs and safety interventions for 2 of 20 sampled residents (Resident #17 and Resident #72). Specifically, the facility didn't address smoking behaviors and supervision for one person and didn't ensure staff implemented established fall prevention interventions for another. The facility reported a census of 63 residents. Findings include: 1. Resident #17's admission Minimum Data Set (MDS) Assessment dated 1/22/26, documented they didn't use tobacco. Resident #17's Smoking Evaluation dated 1/13/26, revealed they smoked 10 or more cigarettes a day in the morning, afternoon, evening, and night. Resident #17's Smoking Evaluation, dated 4/12/26, revealed they smoked 5 to 10 times a day in the morning, afternoon, evening, and night. The undated "Smoking Information," form provided by the facility on 4/13/26, identified Resident #17 smoked and designated the 400 Hall Courtyard as the smoking area. On 4/15/26 at 9:16 AM observed Resident #17 smoking in the designated courtyard with staff present. On 4/16/26 at 9:25 AM observed Resident #17 smoking in the designated courtyard with staff present. Resident #17's Care Plan, initiated 1/16/26, lacked any documentation related to smoking or the necessary supervision for the activity. The facility's "Resident Smoking Agreement" policy, updated 4/14/25, required staff to document all smoking measures on the care plan and communicate them to the staff responsible for supervising people while smoking. During an interview on 4/15/26 at 3:08 PM, the Administrator revealed he expected Resident #17's Care Plan to include their smoking behaviors.	F0656		

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F0656 SS = D	Continued from page 10 2. Resident #72's MDS assessment dated 1/1/26 identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The Fall Follow-Up note dated 7/1/25 indicated Resident #72 reported pain numbness to her left arm after she got it pinned between the bed and side rail. The review of Care Plan Interventions and effectiveness of the new intervention indicated Resident #72's Care Chart didn't have the intervention of fall mat, but was listed on the Care Plan. Resident #72's Care Plan, revised on 4/15/25, directed staff to keep the bed in the low position and ensure a fall mat (a padded mat placed on the floor next to a bed to reduce the risk of injury from a fall) remained in place. Resident #72's Incident Report dated 7/1/25, documented staff found them on the floor with their left arm pinned between the mattress and side rail. The report noted staff failed to place the bed in the low position and failed to put the fall mat in place as required. During an interview on 4/16/26 at 12:25 PM, the Director of Nursing (DON) stated when the staff found Resident #72 on the floor, they didn't have the safety measures in place as they should've. She stated they educated the staff following the event. The facility's "Comprehensive Care Plans" policy, updated 12/3/25, required the facility to develop and implement person-centered care plans describing specific interventions to meet identified needs.	F0656		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880	**F880** In continued compliance with F880, Infection Prevention & Control, Accura Healthcare of Ames corrected the deficiency by educating staff G and staff H on the expectation that proper Hand Hygiene be completed between glove changes when providing care to Resident #26 and all like residents by the DON by 5/8/26. To correct the deficiency and to ensure the problem does not recur, all Facility Nursing Staff were educated on the Facility Hand Hygiene Policy, Hand Washing Competency, and Peri Care Competency and the expectation that proper Hand Hygiene be completed between glove changes when providing care by the DON by 5/8/26. The DON and/or Designee will randomly audit the provision of Peri Care 3x weekly x 4 weeks, 2x weekly x 4 weeks, 1x weekly x 4 weeks, and PRN to ensure compliance. As part of Accura Healthcare of Ames ongoing commitment to quality assurance, the DON and/or Designee will report identified concerns through the community's Quality Assurance Process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165423	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Ames, LLC	3440 Grand Avenue , Ames, Iowa, 50010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 11 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F0880		

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F0880 SS = D	Continued from page 12 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, clinical record review, staff interviews, and policy review the facility failed to maintain infection control practices for 1 of 3 residents reviewed (Resident ##26). The facility failed to complete hand hygiene and change gloves when completing resident care. The facility reported a census of 63 residents. Findings include: Based on record review and staff interview, the facility failed to ensure staff practiced proper hand hygiene to prevent the spread of infection for 1 of 10 sampled residents (Resident #26). Specifically, staff failed to wash their hands or use sanitizer after removing contaminated gloves and before touching clean surfaces or moving between tasks. Resident #26's Minimum Data Set (MDS) Assessment dated 3/10/26, indicated they had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. The MDS identified they depended on staff for toilet hygiene and transfers. The MDS included diagnoses of diabetes and depression. On 4/13/26 at 3:05 PM, observed Staff G, Certified Nurse Aide (CNA), and Staff H, CNA, enter Resident #26's room, apply gloves, and transfer them with a stand-up lift from the wheelchair to a commode. Staff H lowered their pants before they reached the commode. Staff G and Staff H removed their gloves when they exited the room but performed no hand hygiene. Staff G proceeded to the nurse's station while Staff H picked up a lift sling and walked down the hall. On 4/13/26 at 3:35 PM, observed Staff G and Staff H return to Resident #26's room. Staff H applied gloves and cleansed between Resident #26's buttocks, where stool was present. Staff H removed their gloves and applied new gloves without completing hand hygiene, then proceeded to pull up their pull-up and pants. Staff G and Staff H transferred Resident #26 back to	F0880		

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F0880 SS = D	Continued from page 13 the wheelchair. Staff G removed their gloves and proceeded to touch the sling, their clothing, and opened the window, without completing hand hygiene. The facility's "Hand Hygiene" policy, updated 11/13/24, instructed the staff to use proper handwashing techniques to protect against the spread of infection. The policy directed staff to always complete hand hygiene before donning (putting on) gloves, after removing gloves, and after handling contaminated (dirty) items. During an interview on 4/16/26 at 11:42 AM, the Director of Nursing (DON) stated she expected the staff to complete hand hygiene immediately after removing gloves and after completing cares. She added they should perform hand hygiene when going from a dirty task to a clean task.	F0880		