March 12, 2026

Norma House, Administrator
Odd Fellows & Rebekah's Home of Maine
85 Caron Lane
Auburn, ME 04210

To Whom It May Concern

Please accept this plan of correction regarding our February 18 nursing home survey that was conducted at our facility by the Division of Licensing and Certification to determine if Odd Fellows & Rebekah's Home of Maine was in compliance with Federal participation requirements for nursing homes participation in the Medicare and/or Medicaid programs.

Respectfully

Norma House ED
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205170	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOWS HEALTH CARE CENTER	85 CARON LANE , AUBURN, Maine, 04210

(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 From 2/17/2026 through 2/18/2026, on-site visits were conducted at Odd Fellows Health Care Center for the purpose of a Recertification Survey. It was determined that Odd Fellows Health Care Center was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F0000	Please note the filling of this plan of correction does not constitute an Admission of the Allegations set forth In the statement of Deficiencies. The facility is filing this plan of Correction in accordance with Applicable law.	
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to obtain informed consent for treatment with psychoactive medications including the risks and benefits of treatment for 1 of 5 sampled residents reviewed for psychoactive medication use, (#3). Findings: Resident #3 was admitted to the facility in May of	F0552	The DON or designated individuals will audit charts for psychotropic consents x 1 for all current residents, then monthly x 6 months and then at random. Results to be reported to the facility QA committee.	3/4/26

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
Nina Hume	Executive Director	3/2/26

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F0552 SS = D	Continued from page 1 2025. Resident #3's physician order dated 12/16/25 directed staff to administer the medication, Duloxetine HCl Capsule Delayed Release Particles 60 milligrams (MG) Give 1 capsule by mouth one time a day related to alcohol abuse. Resident #3's physician order dated 12/16/25 directed staff to administer the medication, TraZODone HCl Tablet 50 MG Give 0.5 tablet by mouth at bedtime and Give 0.5 tablet by mouth every 12 hours as needed for aggressive or on edge related to Anxiety Disorder. Resident #3's medical record was reviewed and lacked evidence that Resident #3 and/or Resident #3's representative was informed of the risks and the benefits of treatment with these medications and lacked evidence that Resident #3 and/or Resident #3's representative had consented to treatment with these medications. On 2/18/26 at 8:20 a.m., in an interview with a surveyor, the Administrator and the Director of Nursing confirmed the findings.	F0552		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F0584		

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F0584 SS = D	Continued from page 2 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment on 2 of 2 wings (East and West Wings), a hallway and the laundry room for 1 of 1 facility tours. (2/18/2026) Findings: On 2/18/2026 from 11:05 a.m. to 11:20 a.m., a surveyor did an Environmental tour with the Administrator and the Maintenance Director in which the following findings were discussed and observed. Hallway: - The hallway between the units had three ceiling tiles with brown stains on them. Additionally, the baseboard heating unit had chipped/missing paint creating an uncleanable surface. West Wing: - The wooden television stand, in the dining room, had missing surface sealant exposing untreated wood creating an uncleanable surface. - The large standing floor fan, in the corner to the right of the television stand was dusty/dirty.	F0584	Ceiling tiles changed out, complete audit of condition of celcling tiles completed maintenance director or designated individuals will audit weekly ceiling tiles for good condition x 6 then randomly results reported to QA. Wooden television stand surface repaired to create a cleanable surface. Audits completed weekly x 6 months then randomly reports to QA. Floor fan cleaned and weekly audits by Laundry supervisor or designated individuals x 6 months then randomly reports to QA.	3/3/26 2/19/26 2/18/26

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F0584 SS = D	Continued from page 3 - Resident Room 14- The caulking around the base of the toilet was stained yellowish and was dirty. There was a dirty glove and a soiled towel on the floor under the sink. The baseboard heater had chipped/missing paint creating an uncleanable surface. East Wing: - The solarium baseboard heater and the dining room wall heating unit had chipped/missing paint creating uncleanable surfaces. Laundry Room: - The painted cement floor had chipped/missing paint in many areas of the room creating uncleanable surfaces. The large metal floor water drain cover had chipped/missing paint and was heavily rusted creating an uncleanable surface. There were five ceiling tiles with brown stains on them. On 2/18/2026 at11:20 a.m., in an interview with a surveyor, the Administrator and the Maintenance Director confirmed the discussed and observed findings.	F0584	Caulking around the base of the toilet replaced and cleaned to create a cleanable surface. All baseboard heaters repaired and painted to create a cleanable surface. All areas of chipped/ missing paint repaired and painted to create a cleanable surface. Large metal floor water drain cover painted to create a cleanable surface. Ceiling tiles replaced .Maint. audits weekly x 6 months then randomly.	3/12/26 3/9/26 3/17/26
F0605 SS = E	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of	F0605	Don or designated individual will conduct a weekly audit to maintain that all PRN antipsychotics have a 14-day order x 6 months the at random.	3/4/26

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F0605 SS = E	Continued from page 4 resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F0605		

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F0605 SS = E	Continued from page 5 §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure an as needed (prn) psychotropic medication met the required 14-day limit for 1 of 5 Resident's reviewed for unnecessary medications (Resident #9). Finding: On 2/17/26, a review of Resident #9's current physician orders contained an order dated 1/19/26 for Seroquel (antipsychotic medication used to treat mental health	F0605		

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F0605 SS = E	Continued from page 6 conditions such as schizophrenia and bipolar disorder) 25 milligrams twice daily prn for agitation related to severe dementia with no stop date. The medical record lacked evidence of clinical rational to continue the prn psychotropic medication with an extended time frame. On 2/17/26 at 2:20 p.m., during an interview, the Director of Nursing confirmed the above Seroquel prn order initiated on 1/19/26 did not meet the required 14-day limit.	F0605		
F0656 SS = E	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	F0656	The DON or designated individual will audit transfers on all residents' two times per month x 6 months. then at random Report to QA.	3/4/26

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F0656 SS = E	Continued from page 7 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. §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 observation, record review and interview, the facility failed to update and/or implement care plans in the area of transfers for 2 of 2 sampled residents (#28 and #9) reviewed for Activities of Daily Living (ADL). In addition, the facility failed to develop a care plan in the area of bladder and bowel incontinence for 1 of 1 resident reviewed for incontinence (Resident #17) and in the area of Hospice for 1 or 1 resident reviewed for End of Life (Resident #8). Findings: 1. On 2/17/26 at 9:10 a.m., observation of the Certified Nurses Aide (CNA) #1 and CNA #2 transfer Resident #28 from a wheelchair to a recliner by hoisting the resident up from under his/her arms and preforming a pivot transfer, during this transfer the CNA had to grab a hold of the residents pants to assist with the transfer of the residents weight. Review of Resident #28's current care plan in the area of Activities of Daily Living initiated on 3/22/23 stated the resident may use a "hemi-walker to transfer, may use stand/pivot lift when (he/she) is weak." The care plan in the area of falls, last revised on 11/24/25 states "uses Hemi walker for transfer. Uses wheelchair for mobility. Use stand/pivot lift to transfer as needed when (he/she) is weak". On 2/18/26 at 10:36 a.m., during an interview, the Licensed Practical Nurse (LPN)#2 provided the surveyor with the current CNA assignment list which indicated Resident #28 was a sit to stand for transfers. At this time the surveyor discussed the transfer observed on 2/17/26. On 2/18/26 at 10:55 a.m., observation of CNA #2 and CNA #5 transfer Resident #28 from the recliner to a	F0656		

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F0656 SS = E	Continued from page 8 wheelchair by lifting him/her up from under the arms. At this time in an interview with CNA #2, she stated Resident #28 is a 1-2 person transfer but on a better day 1 person can do it stand and pivot. The surveyor asked if a sit to stand lift is used for his/her transfers. CNA #2 stated, "I don't know, we don't use a sit to stand, only if (he/she) is sick or weaker. (He/she) also has a hemi walker, I call it the tripod, I use that with (him/her) if I'm doing (him/her) alone. If I have 2 people, then we just stand (him/her) and (he/she) walks." 2. On 2/17/26 at 9:12 a.m., observation of CNA #1 and CNA #2 transfer Resident #9 from the wheelchair to a recliner by hoisting the resident up from under his/her arms and performing a pivot transfer. On 2/17/26 at 11:33 a.m., during an interview, Resident #9's representative stated when he/she first arrived at the facility, the staff utilized a "machine" to lift him/her for transfers and now they "usually just hold (him/her)". On 2/18/26 at 7:56 a.m., an additional observation of CNA#1 and CNA #5 transfer resident #9 from the bed by hoisting the resident up from under his/her arms and preforming a pivot transfer to the wheelchair. Review of Resident #9's clinical record showed he/she was admitted in January 2026. The current Activities of Daily Living care plan initiated on 1/20/26 and revised on 1/31/26 states Resident #9 requires a Mechanical Lift with 2 staff assistance for transfers. The current CNA assignment list states he/she is a 2 assist with walker for transfers. On 2/18/26 at 11:07 a.m., the above was discussed with Director of Nursing. 3. Record review of Resident #8's medical record contained a Minimum Data Set (MDS) version 3.0 quarterly assessment dated 2/7/26, which stated the resident is receiving hospice care. Review of the resident's current diagnosis stated he/she had started palliative care on 1/16/26. As of 2/17/26 the residents' care plan lacked evidence of development and/or interventions for palliative care. On 2/17/26 at 2:04 p.m. during an interview, the Director of Nursing confirmed the current care plan did not reflect the current needs of Resident #8.	F0656		

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F0656 SS = E	Continued from page 9 4. Record review of Resident #17's medical record contained an MDS annual assessment dated 11/26/25, which indicated the resident is always incontinent of bowel and bladder. As of 2/17/26 the residents' care plan lacked evidence of development and/or interventions for bowel and bladder incontinence. On 2/18/26 at 10:07 a.m. during an interview, the Director of Nursing confirmed the current care plan did not reflect the current needs of Resident #17.	F0656	The DON or designated individual will audit care plans monthly for palliative care and incontinence care monthly x 6 month then at random. Report to QA.	3/12/26
F0677 SS = E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews and record review, the facility failed to provide Activities of Daily Living (ADL) care in the area of personal hygiene for 1 of 1 residents reviewed for oral care (Resident #28) for 2 of 2 days of survey. Findings: On 2/17/26 at 9:10 a.m., observation of Resident #28's teeth to have a white visible coating at the gum line. At this time, the resident stated the staff does not help him/her with teeth brushing and he/she can do it on her own. On 2/18/26 at 10:19 a.m., observation of Resident #28 with a white, thick coating at the gum line. Review of Resident #28's current care plan for "Self-care deficit relating to Cerebral Palsy" initiated on 3/22/23 states the "resident needs extensive assistance with ADL's (Activities of Daily Living). Set up with basin each morning and make sure needed items are within reach. Assist as needed. Allow time to complete tasks on (him/her) own." The current care plan for "ADL self-care performance deficit" last revised on 1/4/26 has an intervention for "oral care routine: brush teeth". Review of the CNA documentation from February 2026	F0677	DON or designated individual will audit oral oral hygiene on all residents weekly x 6 months and then at random. Report to QA	3/4/26

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F0677 SS = E	Continued from page 10 lacks any evidence of personal hygiene being completed. On 2/18/26 at 10:36 a.m., during an interview, the Licensed practical Nurse (LPN)#2, was unable to find documentation of personal hygiene being performed stating, the facility had recently changed to an online documentation system and failed to add the personal hygiene items for CNA's to document care that is being completed and the level of assistance that is needed. On 2/18/26 at 11:07 a.m., the above concern was discussed with the Director of Nursing.	F0677		
F0732 SS = B	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors.	F0732	The DON or designated individual will audit posted staffing weekly x 6 months and then at random. Report to QA	2/19/26

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F0732 SS = B	Continued from page 11 §483.35(l)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(l)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to post the current daily nurse staffing information that includes the facility name, day of the month, a breakdown of the number of registered and licensed nursing staff responsible for direct resident care and indicate which shifts the numbers corresponded to for 2 of 2 survey days. Findings: 1. On 2/17/26 at 8:36 a.m., a surveyor observed that the posted nurse staffing information was for 1/7/26. 2. On 2/18/26 at 8:10 a.m., a surveyor observed that the posted nurse staffing information was for 1/7/26. On 2/18/26 at 10:04 a.m., the Director of Nursing confirmed with the surveyor that there was no current posting of the staffing.	F0732		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F0761	The DON or designated individual will audit the med cart, med room, and med fridge for expired meds weekly x 6 months then at random. Report to QA.	3/4/26

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F0761 SS = E	Continued from page 12 controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, the facility failed to ensure expired medications were removed from the supply available for use in 1 of 1 medication cart observed and 1 of 1 medication room observed. Findings: 1. On 2/18/26 at 8:23 a.m., during observation of the medication cart and medication storage room with the Licensed Practical Nurse (LPN) #1 the following medications were observed to be available for use: The medication cart contained: Opened bottle of ibuprofen 200mg tabs with an expiration date of 12/2025 Opened bottle of Calcium Carbonate 500mg tabs with expiration date of 1/2026 Opened bottle of aspirin 325mg with expiration date of 10/2025 Opened bottle of Vitamin D 10 mcg (microgram) with expiration date of 12/2025 The medication storage room contained: 1 Fleets enema with expiration date of 8/2024 2 bottles of Aspirin 325mg with expiration date of 4/2025 and 1 with an expiration of 5/2025 1 bottle of Calcium Carbonate 500mg tabs with expiration date of 1/2026 1 bottle of Vitamin D 10 mcg with expiration of 11/2024	F0761		

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F0761 SS = E	Continued from page 13 3 bottles of Vitamin B complex with expiration date of 11/2025 2 bottles of multivitamins with expiration date of 11/2025 The refrigerator in the medication room contained 1 opened box of Bisacodyl suppository's with expiration date of 11/2025. On 2/18/25 at 8:42 a.m., the above was discussed with the Director of Nursing	F0761		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, the facility's Temperature Log Policy and the facility's Labeling & Dating Procedure, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for metal duct work, floors, the cook stove, a solid floor pad, a food mixer, a food processor, a table, and a food disposal unit. Additionally, the facility failed to ensure that foods were dated, labeled and/or removed	F0812	Dietary manager or designated individual will conduct weekly audits of food safety requirements to include temperature Log, cleaning log and food labeling pre policy. 6 months then random. Report to QA.	3/12/26

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F0812 SS = E	Continued from page 14 from service past the manufacturer's use by date in a reach-in refrigerator and a walk-in freezer for 1 of 1 kitchen tour (2/17/26). Further, the facility failed to ensure that Daily Dishwasher Temperatures were monitored/documented when reviewed (2/18/26). Findings: The facility's Temperature Logs, updated 1/24/25, noted: It is our policy that temperature logs will be maintained on our: dish machine....The cook on duty will review temperatures and record on each item on each shift. The facility's Labeling & Dating Procedure, updated 1/24/25, noted: Label and date all items. Use masking tape or labeling stickers. Label the date when the item is opened or prepared and write the expiration date three days from the day it is opened or prepared... Unprepared foods that are opened.... Must be thoroughly sealed and dated with the date the item was opened. Throw all items out that are expired.... 1. On 2/17/26 from 8:15 a.m. to 9:00 a.m., a surveyor conducted an initial kitchen tour with the Food Service Director (FSD) in which the following findings were observed: - The metal duct work, running along the kitchen ceiling above food preparation areas, had dust/dirt buildup in many areas. - The kitchen floor had food debris and trash around the entire kitchen, under equipment and under shelving. - The cook stove had dried food particles and dried liquid residue on the cook top surface and the door surfaces. - The solid floor pad, under the stove, had chipped/missing paint creating an uncleanable surface. - The food mixer had dried food particles on it. - The food processor and table it was sitting on had dried food particles on them. - The dish room food disposal unit had dried food particles and dried liquid residue on it. Additionally, the wall mounted fan was heavily soiled with dust/dirt. - The reach-in refrigerator had a large plastic container of pizza dough balls that was unlabeled and	F0812		

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F0812 SS = E	Continued from page 15 undated. Additionally, there were four bags of whipped topping with no thaw date. The manufacturer's directions stated that the product was good for two weeks after being thawed. - The Walk-in freezer had two large bags of popcorn chicken that were unlabeled and undated. On 2/17/26 at 9:00 a.m., in an interview with a surveyor, the Food Service Director confirmed the findings.	F0812		
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: §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;	F0880	Infection preventionist or designated individual will audit all rooms with precautions for compliance and proper procedure weekly x 6 months then at random. staff reeducated on precautions. Report to QA.	3/5/26

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F0880 SS = D	Continued from page 16 (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. 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 observation, interviews, and record review, the facility failed to establish and implement written policies and procedures consistent with nationally recognized infection control guidelines, including Enhanced Barrier Precautions (EBP) and to prevent the transmission of communicable diseases for 1 of 1 resident reviewed for transmission-based precautions. Finding: On 2/17/25 at 8:39 a.m., a Contact Precautions sign was	F0880		

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F0880 SS = D	Continued from page 17 observed posted on the door of Room #9. The sign instructed staff to perform hand hygiene before entering and exiting the room, don gloves and gown prior to room entry, discard gloves and gown before exiting and use dedicated or disposable equipment. Clean and disinfect reusable equipment. A Personal Protective Equipment (PPE) cart was observed outside the room. On 2/17/26 at 9:26 a.m., the surveyor observed Licensed Practical Nurse (LPN) #1 enter Room #9 without donning PPE to administer medication to Resident #4. LPN #1 administered the medication and exited the room without wearing gown or gloves. Upon exiting the room, the surveyor asked LPN #1 what the contact precautions sign posted on the resident's door was for. LPN #1 stated" That's for the girls giving care. I'm only giving him/her medication." LPN #1 acknowledged she did not wear PPE while in the room. When asked to explain contact precautions and what PPE she would wear. LPN #1 stated gloves and gown are to be worn when providing personal care for residents with colostomies or foley catheters. When asked whether she had received Infection Control training related to EBP. LPN #1 stated she was not familiar with EBP. On 2/17/26 at 9:48 a.m. Certified Nursing Assistant (CNA) #2 was asked if she had recently received training regarding Infection Control education including Contact Precautions and EBP. CNA #2 stated she had received training; however, the facility does not utilize EBP and only uses contact precautions. CNA #2 stated that gowns and gloves are not required if staff are not providing direct care. Resident #4's clinical record indicated he/she has a documented history of Extended-Spectrum Beta-Lactamase (ESBL) in the urine and requires extensive assistance with activities of daily living, including personal care. Review of the Facilities Infection Control Manual, last updated for 4/25/25, lacked evidence of written policies or procedures addressing Enhanced Barrier Precautions. On 2/18/26 at 10:57 a.m. During an interview the Director of Nursing stated she assumed EBP were implemented in the facility and was unaware they were not included in the facilities Infection Control Manuel.	F0880		
F0882 SS = D	Infection Preventionist Qualifications/Role	F0882		

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F0882 SS = D	Continued from page 18 CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, the facility failed to designate a qualified staff member to function as the Infection Preventionist, who is responsible for the facility's Infection Control Program, from 8/8/25 to 8/29/25, which has the potential to affect all residents in the facility. Finding: On 2/18/26 at 1:57 p.m., during an interview, the Director of Nursing (DON) stated the previous Infection Preventionist separated employment on 8/7/25. The DON further stated that on 8/8/25, another staff member was asked to assume the Infection Preventionist role. Review of training documentation revealed the newly designated Infection Preventionist completed the required Infection Prevention training on 8/29/25. The facility was unable to provide documentation demonstrating the individual had completed required Infection Preventionist training prior to assuming the role of the Infection Prevention and Control program. On 2/25/26 at 3:00 p.m., the above finding was confirmed with the Administrator.	F0882	One person is designated as the infection preventionist with training and certification. Currently facility has 3 trained and certifications to cover the infection preventionist.	8/29/25 3/10/26

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