| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105255 | A. Building<br>B. Wing | 07/31/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| John Knox Village of Pompano Beach | 700 SW 4th Street<br>Pompano Beach, FL 33060 |

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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>(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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to follow the professional standards of practice regarding the care and management of a resident receiving a nebulizing therapy for 1 of 3 sampled residents (Resident #96); failed to conduct an electrical safety inspection for a nebulizing treatment machine for 1 of 3 sample residents (Resident #92); failed to follow their own policy for verifying a practitioner's orders for nebulizing therapy for 1 of 3 sampled residents (Resident #156); failed to comply with the standards of transmission-based precautions during a nebulizing therapy; and failed to care and manage the nebulizing therapy supplies after a treatment for 1 of 3 sampled residents (Resident # 96). The findings include: A review of a facility policy titled, Nebulizer Therapy, with a revision date of 01/25, revealed the following: Nebulizer treatments, once ordered, is to be administered by nursing staff as directed using proper technique and standard precautions; verify practitioner's order (1); don gloves and other protective equipment (PPE) as needed to comply with standard transmission based precautions (5); disassemble and rinse the nebulizer with sterile or distilled water and allow to air dry (16). 1) Record review revealed Resident #96 was admitted to the facility on [DATE] with diagnoses that included Cerebral Hemorrhage, Atrial Fibrillation, Presence of Cardiac Pacemaker, Hypertension, Monoplegia of an Upper Limb following Non-Traumatic Intracerebral Hemorrhage affecting Left Non-Dominant Side and Generalized Muscle Weakness. Review of physician orders dated 04/10/25 documented an order for Ipratropium Albuterol solution 0.5-2.5, 3 MG (milligram) per 3 ml (milliliters), 1 vial, inhale orally three times a day for wheezing. During an observation conducted on 07/31/25 at 8:45 AM, it was revealed there was no facility nurse inside the room when Resident #96 was receiving nebulizing therapy. A private aide came in a few minutes later followed by a facility nurse who stated she checked on another resident's condition in another room. When she was asked about the time she started the nebulizing treatment, she did not give a response. When she was asked if she usually leaves the resident who is undergoing a nebulizing therapy, she responded, she left to check on another resident. After the nebulizing treatment was completed on 07/31/25 at 9:28 AM, Staff B, Registered Nurse (RN), removed the nebulizing face mask from the resident using her bare hands. She was observed with long fingernails, and she did not perform hand hygiene before removing this resident's mask. She then went to the resident's bathroom, left the resident's room with the face mask on her hand open to air, went to the medication storage room, stating she needed distilled water to clean the facemask. She spent a few minutes unlocking the refrigerator with a set of keys in one hand and a used face mask on another while searching for a bottle of distilled water. When she did not find any, she picked up a stethoscope that had been placed by the Director of Nursing (DON) next to the refrigerator a few seconds earlier. Staff B went back to the resident's room and rinsed the nebulizing facemask using the bathroom sink's tap water. After storing the face mask, she left the resident's room on 07/31/25 at 9:34 AM without assessing the resident's respiratory rate, lung sounds, pulses, blood pressure and post treatment reactions. In an interview with Staff B, on 07/31/25 at 3:33 PM, she was asked why she did not take the resident's vital signs and lung sounds after providing the treatment this morning, and responded, she was so busy and had to attend to another resident. 2) Record review revealed Resident #92 was admitted to the facility on [DATE] with diagnoses that included Obstructive and Reflux Uropathy, Generalized Muscle Weakness, Urinary Retention with Chronic Indwelling Urinary Catheter, Urinary Tract Infection, Communication Deficit, and Chronic Obstructive Pulmonary Disease. Review of the most recent Minimum Data Set (MDS) assessment, under Section C revealed a Brief Interview of Mental Status (BIMS) score of 6 indicating Resident #92 had severe cognitive impairment. Review of physician orders dated 02/13/25 documented orders as, Ipratropium-Albuterol solution 0.5-2.5 (3 MG per 3 mL), give 1 vial, to inhale orally two times a day. An observation on 07/28/25 at 10:45 AM revealed a nebulizing treatment machine on top of Resident #92's bedside drawer that had an electrical safety inspection due date of 05/2024. It was revealed that the last inspection was on 05/2023. In an interview with Staff B, an RN on 07/31/25 at 9:35 AM, when she was asked who is responsible for maintaining and cleaning the nebulizing machine, she responded, The maintenance staff cleans and checks them, but I do not know how often they do them. In an interview with Staff D, Life and Safety Coordinator on 07/31/2025 at 2:53 PM. she stated the last inspection of all respiratory equipment was done on May 31, 2025, and that nebulizing machine must have been missed by the staff for Resident #92. This surveyor provided her with the name and the serial number of the nebulizing machine, but this staff could not locate the machine from her list. She |

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| | 105255 | A. Building<br>B. Wing | 07/31/2025 |

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|---|---|
| John Knox Village of Pompano Beach | 700 SW 4th Street<br>Pompano Beach, FL 33060 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>(continued on next page) |

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| | 105255 | A. Building<br>B. Wing | 07/31/2025 |

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|---|---|
| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, interviews and record reviews, the facility failed to follow the professional standards of practice regarding following physician orders of not taking blood pressure (BP) on the left arm for 1 of 1 sampled dialysis resident (Resident #9). The facility also failed to follow the physician order for fluid restriction for 1 of 1 sampled dialysis resident (Resident #9). The findings include: Review of a facility policy titled, Dialysis Care and Services, undated, revealed that elder guests who require dialysis receive such care and services consistent with professional standards of practice, the comprehensive person-centered care plan, and the elder's guest's goals and preferences. Record review revealed Resident #9 was admitted to the facility on [DATE] with diagnoses that included Metabolic Encephalopathy, End Stage Renal Disease (ESRD), and Dependence on Renal Dialysis. Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/08/25, documented under Section C of the Brief Interview of Mental Status (BIMS) revealed a score of 12, indicating Resident #9 had moderate cognitive impairment. Review of a physician's order dated 02/07/25 revealed the following: no blood pressure (BP) on left arm every shift. Review of the nursing care plan revealed an ESRD focus, a goal that Resident #9 will remain free from discomfort or further complications related to renal dialysis and hemodialysis, and an intervention to not use the access site to take blood pressure every shift. An additional record review of the nursing weekly assessment dated [DATE] revealed Staff B, Registered Nurse (RN), took Resident #9's Blood Pressure (BP) on the left arm. A further review of the electronic health record (EHR) revealed from 05/25 until 06/25, nursing staff documented that the BP was taken during the following morning and afternoon hours using Resident #9's left arm: 05/01/25 at 8:20 AM, while this resident was sitting, documented by Staff B, RN. 05/08/25 at 9:52 AM, while this resident was sitting, documented by Staff B, RN. 05/13/25 at 9:56 AM, while this resident was lying, documented by Staff K, LPN (Licensed Practical Nurse). 05/15/25 at 12:35 PM, while this resident was sitting. 05/29/25 at 09:40 AM, while this resident was sitting, documented by Staff B, RN. 05/30/25 at 4:16 PM, while this resident was sitting, documented by Staff B, RN. 06/08/25 at 10:12 AM, while this resident was lying, documented by Staff K, LPN. 06/09/25 at 4:46 PM, while this resident was lying, documented by Staff K, LPN. 06/10/25 at 9:33 AM, while this resident was lying, documented by Staff K, LPN. 06/12/25 at 09:31 AM, while this resident was sitting, documented by Staff B, RN. 06/21/25 at 3:37 PM, while this resident was sitting, documented by Staff B, RN. In an interview conducted with Staff K, (LPN) on 07/30/25 at 11:00 AM, she stated that Nurses do not take BP on the left arm of Resident #9. When asked if she documents what elder's arm she uses during BP monitoring, she stated she documents in PCC (EHR), and she uses the right arm. She stated that only Nurses take the BP readings and complete the BP documentation in PCC. In an interview conducted with the Nurse Educator on 07/30/25 at 3:33 PM, when he was asked about the professional standards for a resident receiving dialysis treatment, responded BP must not be taken on the arm where dialysis access site is located. When he was shown the Nurses' BP documentation for Resident #9 in the EMR, he confirmed that Resident #9's BP readings were taken on the left arm in May and June 2025 based on Nurses' documentation in the EMR. In an interview conducted with Staff B, RN on 07/31/25 at 11:00 AM, when asked about BP monitoring of an elder on dialysis, she responded, The BP is not taken on the dialysis site. When asked if she documents what site she uses during BP monitoring, she responded, Yes, I document in PCC the elder's' arm I use to take the elder's BP. A computerized record review on 07/31/25 at 2:40 PM revealed the following physician orders dated 02/19/24 as follows: Fluid restriction: 7 PM-7 AM Shift, Med Pass at 9 PM of 120 ml, Med Pass at 6:30 AM of 60 ml, with a total of 180 ml every night shift. Fluid Restriction: 7AM-7 PM Shift Med Pass at 8 AM of 120ml for Breakfast, Nepro 240 ml for Lunch, 240 ml Med Pass at 2 PM, 60 ml Med Pass at 5 PM, and 120 ml for dinner, for a total of 1,020 ml everyday shift. On 2/21/25, an additional Fluid Restriction order revealed:1200 ml per day, diet regular texture, thin consistency, See orders for fluid breakdown per shift. Review of the nursing care plan dated 04/01/24 revealed the resident is at risk for dehydration or potential fluid deficit related to fluid restriction. The interventions included educating the resident/family/caregivers on importance of fluid intake. Review of a document titled, Task: Nutrition, how many ccs (cubic centimeter) did the resident consume with the meal?, submitted by the Registered Dietician (RD) and the DON on 07/30/25 at 3:30 PM revealed Resident #9's daily fluid consumption: On 7/17/25 =400, 400, 120 = 920 (cc/centimeter) (ml/milliliters) On 7/18/25 =8, 8, 500= 516 cc. On 7/19/25=240, 60 = 300 cc. On 7/20/25= 8, 8, 60= 76 cc. On 7/21/25= 240, 240, 60=40 cc. On 7/22/25=220, 220, 240=680 cc. On |

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| | 105255 | A. Building<br>B. Wing | 07/31/2025 |

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| John Knox Village of Pompano Beach | 700 SW 4th Street<br>Pompano Beach, FL 33060 |

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|---|---|
| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to follow the approved menu for substitutions for residents with orders for mechanically altered diets for 3 of 27 sampled residents with orders for mechanical soft diets (Resident #18, #178 and #182). The findings included:Record review revealed the approved menu for the lunch meal on 07/28/25 documented that residents with orders for Mechanical Soft textures were to be served three-bean salad in place of coleslaw. The approved menu for the breakfast meal on 07/29/25 documented that residents with orders for Mechanical Soft textures were to be served bite sized sausage patties in place of bacon strips 1. Resident #178 was admitted to the facility on [DATE]. According to the resident's admission Evaluation, with a reference date of 07/23/25, Resident #178's cognition was documented as 'Alert and lethargic', with unclear speech and was 'sometimes' able to understand. The assessment documented that the resident was dependent upon staff for all activities of daily living (ADLs). Resident #178's diagnoses upon admission included: Metabolic Encephalopathy, Dysarthria following Cerebrovascular disease, DM (Diabetes Mellitus), COPD (Chronic Obstructive Pulmonary Disease), fracture of shaft of right tibia and patella, Acute Embolism and Thrombosis of left Femoral Artery, Myocardial infarction, Rheumatoid arthritis, Spinal stenosis, Radiculopathy of cervical region, GERD (Acid Reflex), Sepsis, Paroxysmal atrial fibrillation, Presence of Cardiac Pacemaker, Hearing loss bilateral, Dementia, Hypertension, Hyperlipidemia, Heart failure, Dysphagia, Iron Deficiency Anemia. The admission Assessment documented, Resident is not capable of understanding/contributing to/making his/her own plan of care Resident #178's Baseline care plan, with a reference date of 07/24/25 documented:I am at risk for an alteration in my nutrition and hydration status.Goal: I will have no significant weight changes and will remain adequately hydrated through the next review date.Interventions:Provide my diet as orderedHave my food preference discussed as neededI need assistance with meals Resident #178's diet orders included:Regular diet, Mechanical Soft Bite size texture, Thin consistency - 07/24/25 1a. During an observation of the lunch meal served on the Orchid unit (2200 unit), on 07/28/25 at 1:04 PM, Resident #178 was served a side of cole slaw in a bowl instead of the three bean salad that was on the menu as a substitute for the cole slaw based on the resident's diet order. During an interview at the time of the observation, Staff I, Cook, stated that she was unable to communicate with Resident #178 due to being deaf and stated that she was unaware of the order for Mechanical soft Bite Size texture foods. 1b. During an observation of breakfast on the Orchid Unit, on 07/29/25 at 8:45 AM, Resident #178 was served intact bacon strips instead of the bite sized sausage pattie that was on the menu as a substitute for the bacon based on the resident's diet order. During an interview, at the time of the observation, Staff J, [NAME] stated that she was not aware of the order for Mechanical Soft and bite-sized texture. During an interview, on 07/29/25 at 8:50 AM, the Speech Language Pathologist (SLP) acknowledged that the intact bacon is not safe for someone with orders for Mechanical Soft texture foods. 2. Record review revealed Resident #18 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, a Significant change Minimum Data Set, with a reference date of 07/12/25, documented Resident #18 had a Brief Interview for Mental Status score of 12, indicating a moderate cognitive impairment. The assessment documented that Resident #18 required 'supervision or touching assistance' for eating. Resident #18's diagnoses at the time of the assessment included: Cancer, Atrial fibrillation, Heart failure, Hypertension, Gastro-esophageal Reflux disease (GERD, Benign prostatic hyperplasia, Hyperlipidemia, Depression, Chronic lung disease, Muscle weakness, Dysphasia, Cognitive communication deficit, Need for assistance with personal care and Presence of cardiac pacemaker. Resident #18's diet orders included:Mechanical Soft Bite Size - May have bacon - 06/05/25 with a revision date of 07/08/25. During an observation of lunch served on the Orchid unit, on 07/28/25 at 1:04 PM, Resident #18 was served a bowl of cole slaw instead of the three-bean salad that was on the menu as a substitute for the cole slaw based on the resident's diet order. During an interview, on 07/29/2025 8:50 AM, with the SLP, when asked about residents with orders for mechanical soft bite sized textures being served cole slaw, the SLP stated that the cole slaw would be fine for residents. During an interview, 07/30/25 at 3:00 PM with Staff H, Registered Dietitian, when asked about cole slaw and bacon strips being served to residents with orders for Mechanical Soft and bite sized foods, Staff H replied, Residents with Mechanical soft orders should not be served raw crunchy vegetables, the extension says 3-bean salad. 3. Resident #182 was admitted to the facility on [DATE]. According to the resident's admission assessment, with a reference |

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|---|---|
| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide the correct diet consistency for the Mechanical Soft diet for 3 of 3 sampled residents reviewed for Nutrition (Resident #32, Resident #177 and Resident #162).The findings included:1. Record review revealed Resident #32 was admitted to the facility on [DATE] with diagnoses of Parkinsons Disease without Dyskinesia and Chronic Obstructive Pulmonary Disease. The admission Medicare - 5 Day Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident's Brief Interview of Mental Status (BIMS) score was 13, which indicates intact cognition.A review of physician orders dated 07/14/25 revealed the following: Regular diet, Mechanical Soft Ground/Moist texture and thin consistency.In an observation conducted on 07/28/2025 1:00 PM, this surveyor observed that Resident #32's meal tray consisted of a chopped crispy fish sandwich. The bread was cut into two triangular pieces without borders.2. Record review revealed that Resident #177 was admitted to the facility on [DATE] with diagnosis of orthopedic aftercare and displaced intertrochanteric fracture of left femur. The Discharge Return Not Anticipated /End of PPS Part A Stay Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident's Brief Interview of Mental Status (BIMS) score was 12, which indicates mild cognitive impairment.A review of physician orders dated 07/21/25 revealed the following: Regular diet, Mechanical Soft Ground/Moist texture, thin consistency.In an observation conducted on 07/28/2025 at 1:07 PM, this surveyor observed that Resident #177's meal tray consisted of a soup and an entire slice of bread with borders of which the resident had already taken one bite. 3. Record review revealed that Resident #162 was admitted to the facility on [DATE] and discharged on 07/28/2025 with diagnosis of metabolic encephalopathy and anemia. The admission /Medicare - 5 Day Minimum Data Set (MDS) dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score is 10, which indicates moderate cognitive impairment.A review of physician orders dated 05/27/25 revealed the following: Regular diet, Mechanical Soft Ground/Moist texture, thin consistency.In an observation conducted on 07/28/2025 at 12:49 PM, this surveyor observed that Resident #162's meal tray consisted of big chunks of pear, chopped breaded fish and 2 slices of bread cut in half.In an interview conducted on 07/30/2025 at 3:00 PM with Staff H, Registered Dietitian stated that the breading on the fish is flaky and thin, not fried but baked. The fish comes precooked for any diet. Staff H explained that mechanical soft diets should be cut in bite size. When asked about the fish meal that was served to the residents with orders for mechanical soft, Staff H stated that sandwiches should be cut into bite sized pieces. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to follow the standards or transmission-based precautions for 1 of 3 sampled residents for nebulizing therapy (Resident # 96), for 1 sampled resident for gastrostomy tube feeding (Resident #63), and for 1 of 2 sampled residents reviewed for urinary care (Resident #138). The facility additionally failed to initiate Enhanced Barrier Precautions (EBP) for 1 of 3 sampled residents (Resident #9). The facility also failed to follow its own appearance policy regarding wearing false and polished fingernails for 3 of 3 sampled residents (Resident #96, Resident #138, and Resident #9). The findings include:The findings included: A review of facility's policy titled, Nebulizer Therapy, undated, revealed the following:It is to be administered by nursing staff as directed using proper techniques and standard precautions. [NAME] gloves and other personal protective equipment (PPE) as needed to comply with standard or transmission-based precautions (5).Disassemble and rinse the nebulizer with sterile or distilled water and allow air to dry (16).Wash hands before handling the equipment (#3 on Care of equipment). A review of Center for Medicaid and Medicaid Services (CMS) guidelines for feeding tube revealed the following:Using universal precautions and clean technique and following the manufacturer's recommendations when stopping, starting, flushing, and giving medications through the feeding tube. Ensuring the cleanliness of the feeding tube, insertion site, dressing (if present) and nutritional product. https://www.cms.gov/Medicare/Provider-Enrollment-and Certification/Survey Certification Gen Info /Info/Downloads/CMS-20093-T: ube-Feeding The Center for Disease Control and Prevention (CDC) revealed that Enhanced Barrier Precautions are recommended for residents with indwelling medical devices or wounds, who do not otherwise meet the criteria for Contact Precautions, even if they have no history of MDRO colonization or infection and regardless of whether others in the facility are known to have MDRO colonization.This is because devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring a MDRO and many residents colonized with a MDRO are asymptomatic or not presently known to be colonized.https://www.cdc. gov/long-term-care-facilities/media/pdfs/enhanced-barrier-precautions-sign-P.pdf An additional review of facility's policy titled, Appearance (Human Resources) , undated, revealed the following:The purpose is to create a real home environment by dressing appropriately while maintaining a safe atmosphere.The guiding principles included:Fingernails must always be kept trimmed and clean.If false or polished fingernails are worn by colleague, the colleague must wear a pair of disposable gloves at times while working. 1) A record review revealed Resident # 96 was admitted to the facility on [DATE] with the diagnoses that included Presence of Cardiac Pacemaker, Hypertension, Hypothyroidism, and Facial Weakness following Non-Traumatic Intracerebral Hemorrhage. A review of a physician order dated 04/10/24, documented Ipratropium Albuterol solution 05.-2.5 {(3 mg (milligram) per 3 ml (milliliters)}, 1 vial, inhale orally three times a day for wheezing, During an observation conducted on 07/31/25 at 8:45 AM, Resident #96 was observed alone in the room while receiving nebulizing treatment. She was positioned upright, with a pillow under knees. A few minutes later, Staff B, Registered Nurse (RN) came in on 07/31/25 at 8:51 AM. She stated she just started the treatment a few minutes ago. When she was asked if she must stay in the room with a resident who is receiving nebulizing treatment, she responded that she stepped out to check on another resident. She added that she usually stays with the residents during the 15-minute treatment. When the treatment was completed on 07/31/25 at 9:27 AM, Staff B, RN, without performing hand washing, took the mask from the resident's face wearing no PPE like a pair of gloves. With long nails, she held the nebulizing treatment face mask, went directly into Resident #96's bathroom and started to look for a bottle of distilled water. When she did not find one, she took 2 pieces of paper and placed them under the bottom part of the face mask, while the part that touched the resident's face was exposed to air. She went out of resident's room and travelled the hallway, until she arrived at an office where Narcotic Medications and a refrigerator were kept.With face mask on left hand, she used her right hand to search for a key from her scrub uniform to open the locked refrigerator. The face mask touched both the outside and the inside of the refrigerator, while Staff B, RN was searching for a bottle of distilled water. The Director of Nursing (DON), who was standing at the doorway, went inside the Narcotic Medication room and placed a stethoscope next to the refrigerator on 07/31/25 at 9:30 AM. Staff B, RN picked up the stethoscope. With no distilled water on hand, Staff B went back inside Resident #96's room on 07/31/25 at 9:31 AM. She was still holding the face mask up, exposing it |