STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105819	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Hall Nursing and Rehab Center	1800 SE Hillmoor Drive Port Saint Lucie, FL 34952

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52127 Based on policy review, record review and interview, the facility failed to identify a situation as a credible allegation of verbal abuse and to report the allegation to local Law Enforcement (LE), the State Agency (SA), and the Administrator of the facility, for 1 of 2 sampled residents, Resident #87. The findings included: Review of the policy, titled, Abuse and Neglect Prohibition, revised 08/2023, documented, in part, The definition of Verbal Abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance regardless of their age, ability to comprehend, or disability. The center will investigate any alleged abuse and report such allegations to the state as per state/federal regulation. Review of the record revealed Resident #87 was admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 10, on a 0 to 15 scale, indicating moderate cognitive impairment. During an interview on 02/18/25 at 8:57 AM when asked were you ever physically, mentally or verbally abused, Resident #87 stated, Would you call a punching match with the aide abuse? Resident #87 stated he did not know who the aide was but thought that she still worked there. Resident #87 further stated the incident happened in the past month, and had been investigated and written up. An interview was conducted on 02/18/25 at 3:30 PM with Resident #87's spouse, who stated she was told they did investigate the abuse, because the resident had told his Speech Language Pathologist (SLP), who had then reported it to the Social Services Director (SSD). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 02/19/25 at approximately 4:00 PM with the SSD, who stated that the incident was brought to her attention by Staff M, SLP, and documented as a grievance. The SSD stated the incident included some inappropriate language. Review of the grievance revealed it was filled out and submitted by Staff M, SLP on 02/12/25. This grievance only referred to an exchange of inappropriate language. The SSD stated after the SLP came to her for a grievance, she herself went to speak with Resident #87. The SSD stated Resident #87 told her an aide with glasses tried to give him an injection and the resident called the staff member a F-- B--. The SSD stated there was apparently some inappropriate words said back at the resident, but it could not be substantiated because the SSD was unable to confirm which staff member was involved, and also because aides don't give injections. The SSD stated Resident #87 told his spouse a different account of the incident, but when asked what the spouse was told by her husband, the SSD stated she did not ask the wife. An interview was conducted on 02/19/25 at 4:37 PM with Staff M, SLP, who stated, Let me start by saying that Resident #87 has aphasia and sometimes flip flops words. The SLP stated she asked the resident how his day was going, and he replied not good. The SLP stated the resident said when someone calls him by a certain name it makes him upset. The SLP stated she asked him what was said, and the resident said an aide called him a F-- A--. Staff M, SLP, stated she went to get a form to fill out and was given a grievance form, and asked the SSD for help as this was the first time she filled out this form. The SLP stated when she asked the SSD for help with filling out the form, the SSD advised her not to use the exact words that were said, but instead use staff inappropriately spoke to him. When asked if she would consider being called a F-- A-- verbal abuse, the SLP stated, Yes. When asked if she told the SSD the exact words that Resident #87 said, the SLP stated she did. On 02/19/25 at 5:33 PM, an additional interview was conducted with the SLP, SSD, accompanied by the Administrator, the Corporate Nurse, and Director of Nursing (DON). Staff M, SLP, again stated that she was told by Resident #87 that a woman had called him a F-- A--. The SSD then retold the incident, and stated there was an exchange of words but did not recall the SLP telling her exactly what the staff member said to Resident #87. The SSD stated she felt there were inconsistencies to the incident, but that she spoke to every staff member on duty that day and they all said no to the allegation. During this continued interview, when asked if calling a resident, a F-- A-- should be considered verbal abuse, the SSD stated, Yes. When asked why she did not report the incident as an abuse allegation, the SSD stated, I did not think it was reportable because I was unable to confirm it. When asked if an allegation of abuse needed to be substantiated or confirmed prior to reporting it, she replied, No.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52179 Based on observation, record review, and interview, the facility failed to change the indwelling urinary catheter for per the physician order for 1 of 1 sampled resident, Resident #79, reviewed for urinary catheter. The findings included: 1. Record review revealed Resident #79 was admitted to the facility on [DATE] with a medical diagnosis for the indwelling catheter as Urinary Retention. Resident #79 had a history of recurrent Urinary Tract Infections (UTIs). The resident had a recent urine culture done on 11/23/24 because the color of the urine was cloudy / milky with sediments and was positive for an UTI. The Foley catheter was last changed on 11/27/24. Review of the current physician order dated 10/21/24 documented that staff were to change the resident's urinary catheter monthly on the 20th, and as needed. An observation was conducted on 02/17/25 at 9:30 AM of Resident #79 who was asleep in bed, and a urinary collection bag was noted hanging below the level of the bed linen, anchored to the bedside. Review of the Treatment Administration Record (TAR) for the months of December 2024 and January 2025 did not indicate that the urinary catheter was changed. An interview was conducted on 02/20/25 at 10:25 AM, with Staff D, East Unit Manager, who when asked about why the urinary catheter was not changed for Resident #79 during the months of December 2024 and January 2025, Staff D reviewed the TAR. Staff D then responded, There is no documentation of this task being performed.

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52248 Based on observation, record review and interview, the facility failed to ensure urostomy (a surgical opening for urine output) care and services for 1 of 1 sampled resident, Resident #73, as evidenced by the failure to use appropriate supplies to prevent leakage. The findings included: Record review revealed Resident #73 was admitted to the facility on [DATE]. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 9, on a 0 to 15 scale, indicating moderate cognitive impairment. This MDS documented the resident had an ostomy and needed substantial to maximum assistance from staff for the care of the device. Further review of the record revealed a physician's order dated 01/13/25 that instructed staff to monitor the urostomy for blockage and or leakage, and if present, to document and notify the physician. A second physician's order dated 01/13/25 instructed staff to change the urostomy bag as needed for hygiene. Review of two current progress notes dated 02/02/25 and 02/11/25, both documented the urostomy bag was changed due to leakage. Review of the current care plans documented Resident #73's dignity would be maintained related to the use of a urostomy. This care plan instructed staff to empty the pouch when it was 1/3 to 1/2 full. An interview was conducted on 02/17/25 at 12:30 PM with Resident #73, who stated, I have an ostomy, and it leaks. They don't have supplies. They are using a diaper to cover the ostomy, and it still gets my clothes wet. During an interview on 02/19/25 at 8:46 AM, when asked about the urostomy for Resident #73, Staff K, Certified Nursing Assistant (CNA), stated she empties the urostomy sometimes two to three times daily because she urinates a lot. The CNA stated, It may leak if it's full and they don't empty it. An observation of urostomy care was conducted on 02/19/25 at 4:31 PM by Staff B, Licensed Practical Nurse (LPN). The LPN had an urostomy bag for the device change, but stated she had been asking for the appropriate bag for a long time. The LPN confirmed during care that Resident #73 had been wearing the wrong type of ostomy bag. During this observation, Staff L, CNA, stated the ostomy bag worn by Resident #73 leaks at times. During an interview on 02/20/25 at 9:04 AM, Resident #73 again confirmed staff had been using the wrong ostomy bags, and that the previously used bags kept leaking. Resident #73 stated the correct bag was now on and that it made it easier to empty independently, without bothering anyone. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 02/20/25 at 9:30 AM, with Staff F, CNA / Central Supply, confirmed she had urostomy supplies for Resident #73 since admission. Staff F stated she speaks with the admission staff to determine the resident's needs. Staff F stated she put the urostomy supplies in the medication room for the nurses to obtain. An interview was conducted on 02/20/25 at 9:41 AM with Staff H, LPN. When asked where the ostomy supplies were kept, she went to the medication room. When asked for a urostomy bag, the LPN stated, I think this is the bag here and held up a colostomy bag. When asked if she was sure it was a urostomy bag, the LPN stated, I guess you have to put something on the end of it (to keep it from leaking). An interview was conducted on 02/20/25 at 11:10 AM with Staff G, LPN. When asked where the ostomy supplies were kept, she went to the medication room. When asked which supplies would be used for the urostomy for Resident #73, Staff G stated, I would use this and held up a colostomy bag and skin prep. Photographic Evidence Obtained. Staff G, LPN confirmed she had taken care of Resident #73 and that the resident had a urostomy. .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52248 Based on policy review, observation, record review and interview, the facility failed to ensure adequate nutritional status for 2 of 5 sampled residents, as evidenced by failure to weigh Resident #99 and implement fortified foods, and failure to monitor meal intake for Resident #69, both who had significant weight loss. The findings included: 1. Review of the policy, titled, Weight Measurements, revised: 08/2023, documented, in part, Residents are weighed weekly, monthly, or according to physician orders. Residents should be weighed at the same time of the day, in similar clothing, and using the same scale. Any significant or progressive weight loss or gain is noted and reported to the residents' attending physician, family, or responsible party, and documented in the medical record. Note all new admits should be weighed weekly for 30 days. Record review revealed Resident #99 was admitted to the facility on [DATE]. Review of the Current Minimum Data Set (MDS) assessment, dated 02/19/25, documented the resident had a Brief Interview for Mental Status (BIMS) score of 3, on a 0 to 15 scale, indicating severe cognitive impairment. Review of the matrix provided by the facility dated 01/17/25 indicated Resident #99 had excessive weight loss. Further review of the record revealed a documented weight of 227.8 pounds on 01/15/25 and on 02/05/25, a documented weight of 212.2 pounds. Resident #99's second documented weight was 21 days after the initial weight on 01/15/25. Resident #99 had a significant decrease in weight of 15.6 pounds, which was a 6.85 % weight loss in less than 30 days. Review of a physician order dated 02/15/25, written by the Registered Dietitian (RD), documented Resident #99 was to receive Fortified Foods Supplements with each meal. Review of the current care plans initiated on 01/24/25, documented Resident #99 was at risk for decreased nutritional status and dehydration related to decreased mobility, and dementia, with a goal the resident will be free of significant weight changes. During observation of the lunch meal provided to Resident #99 on 02/19/25, the tray that was served lacked fortified foods. Photographic Evidence Obtained. As per the Certified Dietary Manager CDM), the fortified food item was mashed potatoes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/20/25 at 10:20 AM, when asked who was responsible for taking and recording weights, the RD stated The Restorative CNA (Certified Nursing Assistant) takes the weight, they are written in a book and the book is with the CDM. As far as the weights, I'm not in charge of that, the CDM puts them into the computer. When asked when she see residents for follow up after the initial nutrition assessment, if there is a weight loss problem, the RD stated, We look for updated weights and we see the resident when we are able to; at that time the dietician will put an order in the record if needed, whatever recommendations the dietician has, goes on a nutrition recommendation tracking sheet and it is sent to the CDM by email. The CDM is responsible for initiating the supplement orders. When asked how she follows up to ensure the order was initiated, the RD stated We do an audit, to compare our orders to what's in the CDM's system. I actually started the audit yesterday and I didn't finish. A copy of the nutrition recommendation form dated 02/14/25 for Resident #99 was provided by the RD as requested, that included the recommendation for fortified foods for Resident #99, dated 02/14/25. Photographic Evidence obtained. During an interview on 02/20/25 at 1:15 PM with the CDM, when asked if he received the nutrition recommendation form for Resident #99, he stated, I would have to look at my emails to see if I received the form for that resident. I just realized this morning that there was a check mark button that I must click for fortified foods to show up on the meal ticket, so that's probably why he hasn't received any fortified foods, but it should be on his ticket now. When asked who was responsible for inputting the weights into the resident's record so that the RD could review them, the CDM stated, I see the weights and enter them in the record and then the RD has access to see the weights. 38893 2. Record review revealed Resident 69 was admitted to the facility on [DATE]. Review of the resident's most recent complete assessment, a Significant Change Minimum Data Set (MDS), dated documented Resident #69 had a Brief Interview for Mental Status (BIMS) score of 03, indicating severe cognitive impairment. Resident #69's diagnoses at the time of the MDS included Atrial Fibrillation, GERD (Gastroesophageal Reflux Disease), Athritis, Osteoporosis, Non-Alzheimer's Dementia, Parkinson's Disease, Depression, Hereditary and idiopathic neuropathy, Osteomyelitis of vertebra, Cognitive communication deficit, Pressure ulcer of sacral region, and Myalgia. Resident #69's diet orders included: Regular diet, Pureed texture, Thin Liquids consistency - large portions with all meals; No red meat/pork - 10/10/24 with a revision date of 01/23/25. Fortified Foods - with meals for nutrition support w/ L-, D- (no hot cereal - 09/27/24 with a revision date of 11/21/24. House Stock Protein Supplement - two times a day for wound healing 30ml BID [twice daily] until PI [pressure injury] resolved - 10/21/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Med Pass 2.0/Ready Care 2.0 - after meals for nutrition support r/t weight loss 120 ml TID after meals - 01/23/25. Resident #69's care plan for nutrition, initiated on 10/21/24 with a revision date of 02/17/25, documented, Resident is at risk for decreased nutritional status & dehydration r/t Decreased Mobility, Dementia, altered nutrition related labs, Dysphagia, mechanically altered diet, Inadequate PO (oral) intakes, Unplanned weight loss. The goals of the care plan were documented as: o Resident will be free from significant weight changes through the review date Target Date: 03/23/2025 o Resident will maintain nutritional comfort through food/fluids of choice, as able, through the review date. Target date 03/23/25. Interventions to the care plan included: o Observe PO (oral) intakes. o RD/DTR to evaluate as needed. On 08/08/24, the resident weighed 113 lbs. On 02/13/25, the resident weighed 99 pounds which is a -12.39 % Loss. On 11/07/24, the resident weighed 108 lbs. On 02/13/25, the resident weighed 99 pounds which is a -8.33 % Loss. A Dietary Note, dated 02/06/25, documented, Resident presents significant weight loss x 90 x 180 days. Resident has experienced chronic weight loss since June despite supplements .Monitor weight, intake . A Dietary Note, dated 01/23/25, documented, Resident presents significant weight loss x 30 x 90 x 180 days . Monitor weight, intake Additional Dietary Notes, dated 01/10/25 and 12/12/24, documented recommendations to monitor intake. Review of Resident #69's electronic health records revealed there was no documentation of intake for the breakfast meal and the lunch meal on 5 days during the 21-day look back period 01/31/25 to 02/20/25. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 02/19/25 at 1:32 PM with the Diet Tech, when asked about Resident #69's weight loss, the Diet Tech replied, She is not able to answer questions, I ask the residents about their food preferences and relay the information to the kitchen. They should be documenting every meal. When I saw her last week, she was cleaning her plate. When she is not eating or we notice that she is eating less, we contact the MD [Medical Doctor] and see about ordering an appetite stimulant for her. She has weight loss and a pressure ulcer. I am supposed to see them once a week. If she starts eating less, they are supposed to notify me verbally or dietary consult on PCC (Point Click Care - electronic health records). Usually if they see me, they will let me know if somebody is eating less. During the interview, the Diet Tech acknowledged that staff had not been documenting the residents' intakes according to her recommendations. During an interview, on 02/19/25 at 3:07 PM Staff G, LPN, when asked about documentation of a resident's intake, Staff G replied, it should be in the Treatment Administration record (TAR) and it would ask us how much her intake is and I put it in. The CNA will document how much they eat on their tray under tasks. During an interview, on 02/19/25 at 3:14 PM, with Staff H, CNA, when asked about monitoring and documenting a resident's meal intake, Staff H stated that intake is documented in the tasks section of the electronic health records with each meal.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52248 Based on policy review, observation, record review and interview, the facility failed to ensure that the respiratory equipment was changed and maintained as ordered by the physician for 3 of 4 sampled residents, as evidenced by the nebulizer tubing and mask for Resident #99 were not changed for 2 weeks, and the oxygen concentrator filters were not maintained clean for Residents #70 and #86. The findings included: Review of the policy titled Care and Handling of Respiratory Equipment revised 08/2023, documented in part, Handheld nebulizers (equipment used to administer respiratory treatment) should be changed within every seven days or when obviously contaminated. Empty intermittently used nebulizers after each use and rinse with warm water and allow to air dry. 1. Record review revealed Resident #99 was admitted to the facility on [DATE]. Review of the current Minimum Data Sheet (MDS) dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 03, on a 0 to 15 scale, indicating severe cognitive impairment. A physician's order dated 01/29/25 instructed the staff to change the nebulizer tubing and mask every week on Sunday during the 11 PM to 7 AM shift. Another order dated 01/29/25 further instructed the staff that the nebulizer tubing and mask should be rinsed after each use and allowed to air dry. An observation on 02/17/25 at 10:56 AM, in Resident #99's room on his bedside table, revealed a nebulizer mask and tubing dated 01/29/25. Photographic Evidence Obtained. On 02/19/25 at 1:45 PM, in Resident # 99's room on his bedside table, there was a nebulizer tubing and mask dated 01/29/25 with medication remaining in the medication canister attached to the mask. Review of the February 2025 Medication Administration Record (MAR) documented staff administered a nebulizer treatment on 02/19/25 at 0013 AM (1213 AM). During an interview on 02/19/25 at 1:23 PM with the Director Of Nursing (DON), when asked what the policy for changing nebulizer tubing and mask was, the DON stated, The nebulizer mask is supposed to be changed weekly on Sunday on the 11 to 7 shift. The DON was taken to Resident #99's room where she observed the nebulizer mask dated 01/29/25 and she confirmed that 01/29/25 was written on the nebulizer mask. The DON stated, I can see the 01/29, I can see that it was used. 52127 2. Record review revealed Resident #70 was admitted to the facility on [DATE]. A respiratory care physician's order dated 01/31/25 revealed the resident used Oxygen via a nasal cannula at 2 liters for shortness of breath. Another order dated 02/02/25 instructed staff to change the oxygen tubing and clean the concentrator filter every Sunday night on the 11 PM to 7 AM shift. An observation of the oxygen tubing and concentrator filter on 02/17/25 at 1:17 PM revealed the oxygen tubing was dated 02/16/25, and concentrator filter was dirty with visible dust particles. Photographic Evidence Obtained. (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 02/20/25 at 9:24 AM with Staff D, East Unit Manager, who stated maintenance staff oversees the cleaning of the oxygen concentrator filters. When Staff D was asked if the maintenance staff had access to the medical orders, she replied, No and stated that she did not realize there was a medical order to clean the concentrator filter every Sunday night. Staff D was then asked to locate the oxygen concentrator filter in Resident # 70's room and she did not know where to locate it. She was shown where the oxygen concentrator filter was located and agreed it was dirty. 38212 3. Record review revealed Resident #86 was admitted to the facility on [DATE] with diagnosis to include: Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease and Congestive Heart Failure. Resident #86 had a physician's order dated 07/01/24 for 3 liters of continuous oxygen to be delivered by nasal cannula. On 02/17/25, the oxygen order was changed to 4 liters of continuous oxygen to be delivered by nasal cannula. The resident had a care plan for oxygen therapy related to impaired gas exchange. The oxygen delivery system includes an oxygen concentrator and a nasal cannula which is attached to the concentrator via a humidifier bottle. The oxygen concentrator separates nitrogen from the air around the patient so they can breathe up to 95% of pure oxygen. Located on the back of Resident #86's oxygen concentrator was a filter. The filter removes dust, pollen, and other impurities in the air before reaching the lungs. A physician's order was written on 07/07/24 for Resident #86 to have the concentrator filter cleaned every Sunday. On Monday, 02/17/25 at 11:07 AM, the filter on the oxygen concentrator for Resident #86 was observed. The filter was covered with a large amount of dust. Photographic Evidence Obtained. The documentation was reviewed for the cleaning of the filter, and it was documented that it had been cleaned on the night shift which ended at 7:00 AM on 02/17/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105819	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Hall Nursing and Rehab Center	1800 SE Hillmoor Drive Port Saint Lucie, FL 34952

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52179 Based on policy review, observation, record review and interview, the facility failed to ensure infection control practices for 2 of 12 sampled residents, Resident #79 and #359, as evidenced by the failure to post Enhanced Barrier Precaution (EBP) signage and failure to use Personal Protective Equipment (PPE) during direct care. The findings included: 1. Review of the policy, titled, Isolation- Categories of Transmission Based Precautions. Chapter: Infection and Prevention Control, revised on 06/28/24, documented, in part: Fundamental Information 1.the Infection Preventionist (or designee) determines the appropriate notification to be placed on the room entrance door Enhanced Barrier Precautions 3. Equipment includes the use of gown and gloves during the direct care of resident that consists of close contact such as transferring, indwelling device care and other activities that may have the resident in close contact with the staff member. Record review revealed Resident #79 was admitted to the facility on [DATE]. Review of the current physician's order included Enhanced Barrier Precaution (EBP) for Foley catheter care every shift. A care plan initiated on 10/21/24 documented staff were to use EBP when caring for Resident #79. During an observation on 02/20/25 at 9:30 AM, the room of Resident #79 did not have EBP signage or PPE gown supplies. The resident was observed in a wheelchair enroute to the shower room with Staff E, Certified Nursing Assistant (CNA). Staff E was not wearing a gown when she assisted with the resident's shower. During an interview conducted on 02/20/25 at 9:59 AM, when asked about EBP and PPE for Resident #79, Staff E stated, Infection control lets us know when they [the residents] have precautions and there is a blue bag with gowns and gloves on the door. An interview was conducted on 02/20/25 at 10:12 AM with Infection Preventionist (IP), who stated that she is responsible, along with the Staffing Coordinator for putting the EBP signage and PPE supplies and staff education. The IP stated that she didn't realize the resident had changed rooms and thus missed moving the sign and PPE to the new room. She confirmed that EBP should be used during care for Resident #79. 52248 2. Record review revealed Resident #356 was admitted to the facility on [DATE] Review of the Minimum Data Set (MDS) had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating no cognitive impairment. Review of the admission note dated 02/13/25 indicated the resident had cervical spine (neck bone) surgery on 01/21/25 with staphylococcus bacteria (contagious bacteria) infection to the surgical incision located to the front of the neck, and that a midline (tube in the vein) was observed to the right upper arm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105819	A. Building B. Wing	02/20/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the hospital record documentation dated 02/09/25 indicated that the resident had a staphylococcus epidermidis infection of the cervical spine. Further review of the record revealed two physician's orders dated 02/13/25 and 02/14/25 for the administration of an intravenous (administered through a tube in the vein) antibiotic for the cervical spine infection that was to be administered until 02/23/25. A second order dated 02/14/25 instructed staff that they should be using Enhanced Barrier Precaution (use of gloves and gowns) when administering intravenous medications or providing care to the resident's intravenous site for preventive measures. During observation on 02/17/25 at 10:34 AM, there was no visible indication that Resident #356 was on Enhanced Barrier Precaution and there was no Personal Protective equipment (gowns or masks) for use on the resident's door or near his room. Photographic Evidence Obtained