STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115568	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crisp Regional Nsg & Rehab Ctr	902 Blackshear Road Cordele, GA 31015

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record reviews, and review of the facility's policy titled, Advance Directives, the facility failed to ensure residents/representatives/guardians were informed of and provided written notice of the right to accept or decline medical and surgical treatments and their right to formulate an advance directive for two of two residents (R) (R18 and R79) reviewed.Findings include:Review of R18's electronic medical record (EMR) revealed no documented evidence or signed statement of acknowledgment that the resident and his/her representative were informed or received written information advising of their right to accept or decline medical and surgical treatments and to formulate an Advance Directive.Review of the EMR revealed R18 was admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed R18's Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment.Review R79's EMR revealed no documented evidence or signed statement of acknowledgment, the resident and his/her representative were informed or received written information advising of their right to accept or decline medical and surgical treatments and to formulate an Advance Directive.Review of the EMR revealed resident R79 was admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed R79's BIMS score of 12, indicating moderate cognitive impairment.Interview on 03/25/2026 at 12:25 PM with the Administrator confirmed no evidence was found to support that R18 and R79 and or their representatives had been provided with written information related to their right to accept or refuse medical or surgical treatment and the right to formulate an advance directive, on or after admission to the facility.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policy titled, LTC (long term care) Care Plan, the facility failed to develop a comprehensive care plan for four of 45 sampled residents (R) (R1, R79, R3, and R62). The facility failed to develop the comprehensive care plan for foley catheter for R1 and R62, dialysis care plan for R3, and activities of daily living (ADLs) care plan for R79. This deficient practice had the potential to cause adverse health outcomes, including increased risk of infection related to unmanaged Foley catheter care, complications or missed treatments associated with dialysis needs, decline in functional status due to lack of appropriate ADL support, and overall diminished quality of care and resident well-being due to the absence of individualized, comprehensive care planning.Findings Include: 1. Review of the facility's policy titled LTC Care Plan undated, documented under Policy: . LTC Care Plan Intent: It is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service, and intervention. It is utilized to plan for and manage resident care as evidenced by documentation from admission through discharge for each resident. The care plan will identify priority problems and needs to be addressed by the interdisciplinary team (IDT), and will reflect the resident's initial strengths, limitations, and goals. It is our purpose to ensure that each resident is provided with individualized, goal-directed care, which is reasonable, measurable and based on the resident's needs. A resident should have the appropriate intervention and provide a means of interdisciplinary communication to ensure continuity of resident care. Review of the electronic medical record (EMR) revealed R79 was admitted to the facility on [DATE] with diagnoses that include included but not limited t epilepsy, respiratory failure, unspecified, anxiety disorder, unspecified. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed R79's Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Section GG (Functional Abilities) showed: Dependent for: Toileting hygiene, Shower/bathe self, Upper body dressing, Lower body dressing and Personal hygiene. Review of care plan revealed no care plan for ADLs. Review of Physician's Orders revealed no order with indication for ADL Care. Interview on 03/25/2026 at 2:45 PM with the MDS Coordinator AA confirmed there was no care plan for ADL care. She stated the MDS department was responsible to update the care plan and it was not updated. She confirmed that if there was no care plan for ADL care plan then R79 may not get the care that she needed. She further stated that the Certified Nursing Assistants (CNA)s would not see it on their kardex to know the care to provide. 2. Review of the EMR revealed R62 was admitted to the facility on [DATE] with no diagnosis for Foley catheter indication. Review of the Quarterly MDS dated [DATE] revealed in Section C: (Cognition) a BIMS score of 3, which indicated R62 had severely impaired cognition, Section H (Bowel and Bladder) revealed R62 had (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an external catheter. Review of care plan revealed no care plan for a Foley catheter. Review of Physician's Orders revealed no order with indication for a Foley catheter. Interview on 03/25/2026 at 1:15 PM with Unit Manager (UM) DD revealed she confirmed there was no care plan for R62's Foley catheter. She stated it should be care planned. Interview on 03/25/2026 at 1:20 PM with the Director of Nursing (DON) revealed she confirmed there was no care plan for R62's Foley catheter. She stated that the care plan paints a picture of the residents' care and shows what should be done. Interview on 03/25/2026 at 1:45 PM with the MDS Coordinator AA revealed she confirmed there was no care plan for Foley catheter. She stated the MDS were responsible to update the care plan and it was not updated. Interview on 03/25/2026 at 1:47 PM with MDS EE revealed she confirmed there was no care plan for R62's Foley catheter. She stated that a negative outcome for R62 would be that if the nurses went to the care plan and did not see a care plan for Foley catheter they may not know that he had a Foley catheter and R62 may not receive the care he should receive. She further stated that the Certified Nursing Assistants (CNA)s would not see it on their Kardex to know the care to provide. She stated that the nurse would not know what to do if they did not see it in the care plan and R62 would not get the care that he should receive. 3. Review of the EMR revealed R1 was initially admitted to the facility on [DATE] and re-admitted to the facility on [DATE] with diagnoses that included end stage renal disease and kidney transplant status. Review of the most recent Quarterly MDS dated [DATE] documented R1's BIM status was not conducted due to R1 being rarely or never understood. Review under section H, Bladder and Bowel, revealed that R1 has an indwelling catheter. Review of R1's care plan revealed no documentation of catheter care. Review of R1's physician orders revealed an order dated 11/10/2025 for urinary catheter care as needed, an order dated 11/20/2025 for urinary catheter care every Tuesday, an order dated 11/20/2025 for urinary catheter 16F (French) 10 mL (milliliter) bulb, an order dated 11/10/2025 for changing the indwelling Foley catheter as needed for occlusion or leakage, an order dated 11/10/2025 for checking the placement of the catheter anchor every shift, an order dated 11/10/2025 to change the urinary catheter drainage bag as needed (PRN), and an order dated 11/10/2025 to change the urinary catheter drainage bag every 30 days. Interview with Director of Nursing (DON) on 03/36/2026 at 10:35 AM revealed that the care planning process begins upon a resident's admission. The DON confirmed that catheters and associated care should be included in the care plan. She stated that if a resident was admitted with a catheter, the physician should be contacted and nursing staff were responsible for adding catheter maintenance, such as Foley care, into the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of the EMR revealed R3 was admitted to the facility on [DATE] with no diagnosis for dialysis. Review of the Quarterly MDS assessment dated 01/2026 revealed in Section C, Cognition, R3 had a BIMS score of 13, indicating little or no cognitive decline. Section O, special treatments, procedures, or programs revealed R3 receives dialysis care. Review of physician orders regarding R3 indicates dialysis three days a week, Mon, Wed, and Fri at 2:45 PM. Review of a care plan for R3 revealed no care plan for dialysis. An interview on 03/26/2026 at 10:40 AM with the MDS/Care Plan Coordinator confirmed that R3 did not have a care plan for dialysis. Interview on 03/26/2026 at 10:55 AM with the DON reported that a resident on dialysis should be care planned for dialysis at admission. If a resident does not care have a care plan for dialysis it can lead to a delay in care and possible complications and/or worsening of condition. Interview on 03/26/2026 at 1:15 PM with the Administrator confirmed that a resident should be care planned for any area of need for a resident. Cross reference to F690

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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** Based on observations, staff interviews, record review and review of the facility's policy titled, Foley Catheter Care Policy (Long-Term Care), the facility failed to have order with indication for Foley catheter, and failed to have diagnosis for Foley catheter for one of 12 sampled residents (R) R62 with Foley catheters. This deficient practice had the potential to cause complications and improper care management related to Foley catheter.Findings include: Review of the facility's policy titled Foley Catheter Care Policy (Long-Term Care) dated 06/11/2021 documented 1. Purpose: To ensure safe management of indwelling urinary (Foley) catheters, prevent complications such as Catheter-Associated Urinary Tract Infection, and promote resident comfort and dignity. 2. Policy Statement: Indwelling urinary catheters will be used only when medically necessary, maintained using aseptic technique, and removed as soon as clinically appropriate. All staff will follow evidence-based infection prevention practices.Review of the Electronic Medical Records (EMR) revealed R62 was admitted to the facility on [DATE] with no diagnosis for Foley catheter indication.Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed in Section C: (Cognition) Brief Interview for Mental Status (BIMS) score of 03, which indicated R62 had severely impaired cognition, Section H (Bowel and Bladder) revealed R62 had external catheter. Review of care plan revealed no care plan for Foley catheter. Review of Physician's Orders revealed no order with indication for Foley catheter.Interview on 03/25/2026 at 01:15 PM with Unit Manager (UM) DD revealed she confirmed there was no diagnosis for the Foley catheter and there was no order with indication for Foley catheter. She stated she did not see a diagnosis in the EMR and after searching R62's files, she stated she did not find any documentation of the indication for R62's Foley catheter. UM DD further stated that R62's orders had no indication for Foley catheter. She stated that when there was no diagnosis for Foley catheter the nurses would not know the reason for the Foley catheter and would not provide the care R62 needed. Interview on 03/25/2026 at 01:20 PM with the Director of Nursing (DON) revealed she confirmed there was no diagnosis for R62's Foley catheter. She further stated the orders had no indication for Foley catheter. The DON stated that when she looked in the EMR and in R62's file there was no indication in the EMR for Foley catheter and if there was no indication for the Foley catheter there may not be adequate treatment and care for the resident's condition. Interview on 03/25/2026 at 01:45 PM with the MDS Coordinator AA revealed she confirmed that there was no diagnosis or indication for R62's Foley catheter. The MDS Coordinator stated she was responsible for placing the diagnosis in the EMR and it was not done. She stated that if the resident did not have a diagnosis for Foley catheter or an indication for Foley catheter the nurses would not know why the resident had a Foley catheter. Interview on 03/25/2026 at 01:47 PM with the MDS EE revealed she stated that there should be a diagnosis in the EMR and there was not. She stated the resident would not be treated properly if there was no diagnosis. MDS EE also confirmed there was no order with an indication for a Foley catheter and without a diagnosis, the nurses would not know why the resident had a Foley catheter and the reason they were treating or caring for the resident. She stated that the nurses would not know what to look for in change in condition and signs and symptoms which would be associated with R62's Foley catheter.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and review of the facility's policy titled, LTC- Medication Storage, Medication Administration, Insulin and Insulin Pen Management, Medication Open Date and Eye Drop (Ophthalmic Medication), the facility failed to lock one of four medication carts on the 100 hall and failed to place open dates on two vials of multidose insulin for two residents (R) R66 and R1, two medicated eyedrops for R81 and R63, one insulin pen for R90 and one bottle of blood glucose strips. This deficient practice had the potential to cause unauthorized access to medications and ineffectiveness of medications with no open dates for the residents.Findings include:Review of the facility's policy titled LTC- Medication Storage reviewed December 2025 documented Policy Subject: Medication Storage: 1. Medications must only be accessible to authorized staff, and locked when not under the direct observation of authorized staff, d. The medication cart should always be locked unless in use.Review of the facility's policy titled Medication Administration dated 06/11/2021 documented . 26. The medication cart should always be locked unless in use by the unit nurse.Review of the facility's policy titled Insulin and Insulin Pen Management undated, documented Procedures: 1. Labelling Requirements: All insulin vials and pens must be labelled with Resident name, Date opened; Unlabeled insulin must not be used and must be discarded. 10. Staff responsibility: Licensed nurses and trained medication aides are responsible for: proper labeling and dating.Review of the facility's policy titled Medication Open Date undated, documented Purpose: To ensure all medications are used within safe and effective timeframes after opening, reducing risk of contamination, degradation, or reduced potency. Policy Statement: All medications that are opened, reconstituted, or removed from original manufacturer packaging must be clearly labeled with the date opened and handled according to established beyond-use guidelines. Procedures: 1. Labeling Requirements: 2. All staff must immediately label medications upon opening with: Date opened.Review of the facility's policy titled Eye Drop (Ophthalmic Medication) reviewed December 2025 undated documented Purpose: To ensure all medications are used within safe and effective timeframes after opening, reducing risk of contamination, degradation, or reduced potency. Policy Statement: All medications that are opened, reconstituted, or removed from original manufacturer packaging must be clearly labeled with the date opened and handled according to established beyond-use guidelines. Procedures: 1. Labeling Requirements: All staff must immediately label medications upon opening with: Date opened.Observation on 03/25/2026 at 3:50 PM revealed one medication cart on the 100 hall was observed to be unlocked and unattended. Observation on 03/26/2026 at 9:06 AM during review of nurses' medication cart on the Vent Unit revealed no open dates on one multidose bottle of insulin as part for R66, one multidose vial insulin glargine for R1, one bottle of Olopatadine Hydrochloride ophthalmic solution for R81, one bottle of Olopatadine 0.1% (percent) eye drops for R63, one insulin pen for R90 and one bottle of blood sugar strips.1.Review of the facility's Electronic Medical Records (EMR) revealed R66 was re- admitted to the facility on [DATE] with diagnosis included but not limited to type 2 diabetes mellitus (DM).Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section C (Cognition) Brief Interview for Mental Status (BIMS) R66 was rarely/never understood, Section N (Medication) on hypoglycemic (including insulin). Review of Physician's Orders dated 3/26/2026 documented included but not limited to HumaLOG Injection Solution 100 UNIT/ML (milliliter) subcutaneously every 6 hours for DM.2. Review of the EMR revealed R1 was re- admitted to the facility on [DATE] with diagnosis included but not limited to type 2 diabetes mellitus.Review of the Quarterly MDS dated [DATE] revealed Section C (Cognition) BIMS score for R1 was rarely/never understood, Section N (Medication) on hypoglycemic (including insulin). Review of Physician's Orders dated 11/07/2025 documented included but not limited to Insulin (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Glargine Solution 100 UNIT/ML Inject 22 unit subcutaneously at bedtime for diabetes.3. Review of the facility's EMR revealed R81 was admitted to the facility on [DATE] with diagnosis included but not limited to age-related physical debility.Review of the Quarterly MDS dated [DATE] revealed Section C (Cognition) BIMS score of 15, which indicated R81 had intact cognition. Review of Physician's Orders dated 03/13/2026 documented included but not limited to Olopatadine Ophthalmic Solution 0.2 %, instill 1 drop in both eyes at bedtime for itchy watery eyes.4. Review of the facility's EMR revealed R63 was admitted to the facility on [DATE] with diagnosis included but not limited to allergic rhinitis.Review of the Quarterly MDS dated [DATE] revealed Section C (Cognition) BIMS score of 15, which indicated R63 had intact cognition.Review of Physician's Orders dated 12/18/2024 documented included but not limited to Ophthalmic Solution 0.1 % (Olopatadine HCl) Instill 1 drop in both eyes one time a day for burning eyes 1 drop in each eye daily.5. Review of the EMR revealed R90 was admitted to the facility on [DATE] with diagnosis included but not limited to Type 2 diabetes.Review of Physician's Orders dated 03/12/2026 documented included but not limited to Insulin Lispro Injection Solution (Insulin Lispro) Inject as per sliding scale subcutaneously every 6 hours for hyperglycemia.Interview on 03/25/2026 at 3:52 PM with Registered Nurse (RN) CC revealed he confirmed the drawers of the medication cart were unlocked when he opened all the drawers of the medication cart which were unattended in the 100 hallway. RN CC stated the medication cart should be locked. He stated residents could remove medications from the cart and they would overdose on the medications.Interview on 03/25/2026 at 3:53 PM with Unit Manager (UM) DD revealed she confirmed the drawers of the medication cart in the 100 hallway were unlocked. She stated the drawers should be locked. She further stated that the residents could open the drawers of the cart and take the medications.Interview on 03/26 2026 at 9:06 AM with Licensed Practical Nurse (LPN) II revealed she confirmed and validated that there were no open dates on one multidose bottle of insulin aspart for R66, one multidose vial insulin glargine for R1, one bottle of Olopatadine Hydrochloride ophthalmic solution for R81, one bottle of Olopatadine 0.1% eye drops for R63, one insulin pen for R90 and one bottle of blood sugar strips. She stated open dates should be on blood sugar strips, insulin vials and pens, and eye drops. Interview on 03/26 2026 at 9:17 AM with UM JJ revealed she stated that insulin vials and insulin pens were not good after 28 days of being opened. She stated if they were used on the residents, the insulin would not be effective. Interview on 03/26/2026 at 1:30 PM with the Director of Nursing (DON) revealed she stated medication carts should never be unlocked and unattended. The DON stated her expectations were for the nurses to ensure the medication carts were locked when unattended. The DON further stated that all medications should be dated with the date opened and nurses should ensure open dates were placed on medications when first opened.

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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** Based on observations, staff interviews, record review and review of the facility's policies titled, Infection Control Hand Hygiene Trach Care and Foley Catheter Care, the facility failed to ensure adherence to standard infection control practices, including hand hygiene, maintenance of a clean field, proper PPE use during tracheostomy (trach) care for one of 13 sampled residents (R) R41 with tracheostomy, and failed to ensure appropriate catheter care technique, in accordance with accepted standards of practice for one of 12 sampled R (R62) with foley catheter. This deficient practice had the potential to cause infection, medical complications and improper management care.Findings include: Review of the facility's policy titled Infection Control Hand Hygiene dated March 2023 documented Purpose: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Setting: 1. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a patient. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated surfaces, immediately after glove removal. 2. Healthcare facilities should: Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Presentation (CDC) recommendations.Review of the facility's policy titled Foley Catheter Care dated 06/11/2021 documented 1. Purpose: To ensure safe management of indwelling urinary (Foley) catheters, prevent complications such as Catheter-Associated Urinary Tract Infection, and promote resident comfort and dignity. 2. Routine Care (Daily & PRN (as needed): Perform perineal care at least daily and after bowel movements, clean catheter from insertion site outward with soap and water.Review of the facility's policy titled Trach Care dated 07/07/2022 documented Trach care is performed every/day and as needed (PRN). Trach cleaning is done to prevent nosocomial, pulmonary, and wound infections.1.Review of the Electronic Medical Records (EMR) revealed R62 was admitted to the facility on [DATE] with no diagnosis for Foley catheter indication.Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section C: (Cognition) Brief Interview for Mental Status (BIMS) status 03, which indicated R62 had severely impaired cognition, Section H (Bowel and Bladder) R62 had external catheter. Review of care plan revealed no care plan for Foley catheter. Review of Physician's Orders revealed no orders with indication for Foley catheter.Observation on 03/25/2026 at 2:35 PM during R62's Foley catheter care revealed Certified Nursing Assistant CNA GG used one wipe to clean the foley catheter repeatedly at up and down the tubing without folding the wipe. During the observation CNA GG used another wipe to clean around the scrotum and used the same wipe to clean foley catheter tubing.Interview on 03/25/2026 at 3:53 PM with CNA GG revealed she confirmed she wiped the Foley catheter tubing more than once in the same spot up and down the tubing with the same wipe without folding the wipe or disposing of the wipe. 2. Review of the EMR revealed R41 was admitted to the facility on [DATE]. with diagnosis included but not limited to acute and chronic respiratory failure with hypoxia, cardiac arrest, tracheostomy, dependence on respirator [ventilator].Review of the Quarterly MDS dated [DATE] revealed Section C (Cognition) BIMS, R41 was rarely/never understood, Section 0 (Special Treatments, Procedures, and Programs) R41 received Tracheostomy care and was on Invasive Mechanical Ventilator.Review of Physician's Orders dated 08/05/2025 documented included but not limited to Trach Change: Respiratory Therapist to change Trach Tube- once completed add progress note and notate how resident tolerated trach change every day shift every 45 day(s) for To prevent tracheal stenosis and decrease infection. May change as needed (PRN) for dislodgement or malfunction.Observation and interview on 03/25/2026 at 09:11 AM revealed LPN HH was in the 100 hallway and cleaned the blood pressure cuff, removed her gloves, donned a new pair of gloves without sanitizing her hands and cleaned the blood sugar (continued on next page)

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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	machine. She removed the second pair of gloves, disposed of it in the garbage bin and proceeded to look for medications from the medication cart. LPN HH did not hand sanitize between glove change. Observation on 03/25/2026 at 2:05 PM during R41's trach care revealed Respiratory Therapist (RT) FF removed dressing from the trach site and placed it on the bare bedside table beside the opened sterile trach set, changed gloves and did not hand sanitize, removed inner canular and disposed on bare bedside table. RT FF went in the hallway wearing her gown and gloves on to a cart with wipes which was two rooms down the hallway, returned to the room in the same gown and gloves, and cleaned wiped the bedside table. She then used the same gloves which was used to the clean the trach to press the button on the bed to lower the bed, then pressed the buttons on the ventilator machine to reprogram the machine. Interview on 03/25/2026 at 2:05 PM with RT FF revealed she confirmed she removed the dressing from the trach site and placed it on the bare bedside table beside the opened sterile trach set, changed gloves and did not hand sanitize, removed inner canular and disposed on bare bedside table, went in the hallway wearing her gown and gloves to a cart which was two rooms down the hallway and returned to the room in the same gown and gloves. She confirmed she used the same gloves which were used to clean the trach to press the button on the bed to lower the bed, then pressed the buttons on the ventilator machine to reprogram the machine.Interview on 03/26/2026 at 9:17 AM with Registered Nurse JJ revealed she stated there should be a designated trash bag/bin or area during trach care to dispose of used items. She stated hand hygiene must be completed first before putting on a new pair of gloves hands should be cleaned after removing gloves and before putting on gloves. Interview on 03/26/2026 at 9:29 AM with UM KK revealed she stated her expectations were for hand hygiene to be done before putting on gloves, after removing gloves and between glove change. She stated hands should be sanitized between glove change. UM/RT stated soiled gauze were to be discarded in a garbage can and should not be placed on the bedside table. Interview on 03/26/2026 at 10:04 AM with RN/Infection Preventionist and Educator revealed her expectations were for the staff to practice hand hygiene before entering and after leaving the residents' rooms and between glove change. She stated that once gloves were removed the staff must hand sanitize. Interview on 03/26/2026 at 1:30 PM with the Director of Nursing (DON) revealed she stated hand hygiene must be performed between glove change to prevent infection to the residents. She stated soiled dressings must not be mixed or placed next to sterile dressings or sterile or clean fields as this could lead to cross contamination. The DON stated medication carts should never be unlocked and unattended because the residents may get into the carts.