STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115610	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Candler Skilled Nursing Unit	5353 Reynolds Street Savannah, GA 31405

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 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 observation, staff interviews, record review, and the facility's policy titled Documentation of Patient Care, the facility did not fully develop or carry out a complete personˆcentered care plan for three of 21 sampled residents (R12, R40, and R41). This practice may have contributed to the potential for unmet needs, possible medical issues, or a reduced quality of life for these residents.Findings Include: Review of the facility's policy titled, Documentation of Patient Care, dated 10/17/2025, that the Policy Statement, revealed that It shall be the policy of the [Facility Name] to provide a process for recording patient information in a systematized, clear and concise record. Section Definition of Terms revealed .Care Plan-Addresses primary reason(s) for admission and provides estimated length of stay. Contains outcomes and interventions.1.Review of the Face Sheet revealed that R12 was admitted on [DATE] for a diagnosis of acute kidney injury on chronic kidney injury.Review of Five Day Scheduled Minimum Data Set (MDS) for R12, dated 03/18/2026, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 06 (indicating severe cognitive impairment). Section GG (Functional Abilities and Goals) documented that he resident required partial to moderate assistance to roll left and right, sit to lying, lying to sitting on side of bed and transfers. Section I (Active Diagnosis) revealed diagnosis of but not all-inclusive non-Alzheimer's dementia, acute kidney failure (AKF), Hypertension (HTN), chronic kidney disease (CKD), chronic combined systolic and diastolic heart failure, and atrial fibrillation. Section P (Physical Restraints) documented restraints were not used.Review of care plan for R12, dated 03/14/2026, revealed that bed rails were not addressed as part of the care plan.Review of the physician orders for R12 revealed no order for bilateral upper and lower bed rails.Review of record for R12 revealed no bed rail assessment.Review of Consent Form for Protective Devices dated 03/12/2026 for R12 reflected she was unable to sign documented that side rail use was recommended equipment to be used for positioning and mobility device.Observation on 03/24/2026 at 9:57 AM revealed that R12 in bed with bilateral upper and lower bed rails were in the up position on the bed.Observation on 03/25/2026 at 08:11 AM revealed that R12 in bed bilateral upper and lower bed rails were in the up position on the bed.Observation and Interview on 03/26/2026 at 9:15 AM revealed that R12 had bilateral upper and lower bed rails were in the up position on the bed. R12 states she wants to get up and was yelling out.Observation and Interview on 03/26/2026 at 11:10 AM with Licensed Practical Nurse (LPN) CC confirmed that the resident's bed had bilateral upper and lower bed rails in the up position. She states that resident was confused.Interview on 3/26/2026 at 1:24 PM with LPN BB confirmed that side rails are used for R12 because she was confused and for her safety. The use of four rails is used when no one was at bedside. 2.Review of Face Sheet revealed that R40 was admitted on [DATE] for a diagnosis tension pneumothorax.Review of the Five-Day Minimum Data Set (MDS) for R40, dated 03/24/2026, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 12 (indication moderate cognitive impairment). Section GG (Functional Abilities and Goals) documented that the resident required supervision or touch assistance for sit to lying, sit to stand, and chair to bed transfer. The documentation revealed that rolling left to right and lying to (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sitting was not attempted due to medical condition or safety.Review of care plan for R40, dated 03/18/2026, revealed focus are of restraints use type was side rails times two.Review of the physician orders for R40 revealed no order for bilateral upper and lower bed rails.Review of record for R40 revealed no bed rail assessment.Review of Consent Form for Protective Devices dated 03/18/2026 for R40 documented the use of two side rails was recommended equipment.Observation on 3/25/2026 at 8:05AM revealed that R40 had two upper rails and left lower bed rail in the up position on the bed.Observation on 03/25/2026 at 3:55 PM revealed that R40 had two upper rails and left lower bed rail in the up position on the bed.Observation on 03/26/2026 at 8:25 AM revealed that R40 had bilateral upper and lower bed rails in the up position on the bed. He states he tries to move around in the bed. He states they usually have all the bedrails up.Observation and Interview on 03/26/2026 at 11:03AM with LPN BB revealed that R40 had four bed rails up. She states that the residents sign paperwork for bedrails. She reports that anyone that comes in signs the bed rail form. She states that four bed rails are not considered a restraint. Anytime the resident wants the rail down they can have the rail down. 3.Review of Face Sheet revealed that R41 was admitted on [DATE] status post a closed femur fracture repair.Review of the Five-Day Minimum Data Set (MDS) for R41, dated 03/19/2026, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 11 (indication moderate cognitive impairment). Section GG (Functional Abilities and Goals) documented that the resident required partial to moderate assistance for lying to sitting, sitting to stand, and toilet transfers. The documentation revealed that rolling left to right and sitting to lying was not attempted due to medical condition or safety.Review of care plan for R41, dated 03/19/2026, revealed that bed rails were not addressed as part of the care plan.Review of the physician orders for R41 revealed no order for bilateral upper and lower bed rails.Review of record for R41 revealed no bed rail assessment.Review of Consent Form for Protective Devices dated 03/19/2026 for R40 documented the use of side rail use was equipment recommendation for positioning and mobility device.Observation on 03/25/2026 at 8:20 AM revealed that R41 had bilateral upper and lower bed rails were in the up position on the bed.Observation on 03/25/2026 at 4:05 PM revealed that bilateral upper and lower bed rails were in the up position on the bed.Observation on 03/26/2026 at 10:52 AM revealed that bilateral upper and lower bed rails were in the up position on the bed.Observation and Interview on 03/26/2026 at 11:10 AM with LPN CC confirmed that R41 had bilateral upper and lower bedrails in the up position. She reported that R41 was at risk for falls. She states that the rails are used to prevent falls. LPN CC confirmed that bed rails should be a part of the care plan.Interview with MDS Coordinator on 03/25/2026 at 12:50 PM revealed that baseline care plan was completed by nursing on admission.Interview with Director of Nursing (DON) on 03/26/2026 at 11:25 AM confirmed that R40 care plan was for the use of two side rails. His plan of care did not include more than two bedside rails. She confirmed that R12 and R40 that residents plan of care did not include bed rails. She admits that bed rails are not part of the plan of care because they use the consent forms. She admits that bilateral upper and lower bedside rails are considered restraints.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interview, staff interview, and facility policy, Restraints, the facility failed to ensure that residents (R) (R12, R40, and R41) of 21 residents was free from bedrail restraint. This deficient practice had the potential risk of psychosocial and limited physical activity.Findings Include:Review of the facility's policy titled, Restraints, dated 7/19/2024 revealed that the Policy Statement, stated that It shall be the policy of [Facility Name] to create a physical, social, and cultural environment limiting use of restraint to clinically appropriate and adequately justified situations. [Facility Name] supports all patients' rights to: be free from physical or mental abuse, and corporal punishment; be free from restraint of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff; have restraints imposed to protect themselves, a staff member, or others; and, have the restraint discontinued at the earlies possible times. The Definition of Terms section included that, Items which are protective devices and ar not considered restraints.Bed rails-as long as less than 4 are raised or if the patient can lower the rails when he or she desires. Section titled Procedures, included .C. The use of restraint must be in accordance with order of an LIP (Licensed Independent Practitioner) who is responsible for the care of the patient or authorized to order restraint by [facility Name].1.Review of the Face Sheet revealed that R12 was admitted on [DATE] for a diagnosis of acute kidney injury on chronic kidney injury. Review of Five Day Scheduled Minimum Data Set (MDS) for R12, dated 03/18/2026, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 06 (indicating severe cognitive impairment). Section GG (Functional Abilities and Goals) documented that he resident required partial to moderate assistance to roll left and right, sit to lying, lying to sitting on side of bed and transfers. Section I (Active Diagnosis) revealed diagnosis of but not all-inclusive non-Alzheimer's dementia, acute kidney failure (AKF), Hypertension (HTN), chronic kidney disease (CKD), chronic combined systolic and diastolic heart failure, and atrial fibrillation. Section P (Physical Restraints) documented restraints were not used. Review of the physician orders for R12 revealed no order for bilateral upper or lower bed rails. Review of record for R12 revealed no bed rail assessment. Review of Consent Form for Protective Devices dated 03/12/2026 for R12 reflected she was unable to sign documented that side rail use was recommended equipment to be used for positioning and mobility device. Observation on 03/24/2026 at 9:57 AM revealed that R12 had bilateral upper and lower bed rails were in the up position on the bed. Observation on 03/25/2026 at 08:11 AM revealed that R12 had bilateral upper and lower bed rails were in the up position on the bed. Observation and Interview on 03/26/2026 at 9:15 AM revealed that R12 had bilateral upper and lower bed rails were in the up position on the bed. R12 states she wants to get up and was yelling out. In an observation and Interview on 3/26/2026 at 11:10 AM with Licensed Practical Nurse (LPN) CC confirmed that the resident's bed had bilateral upper and lower bed rails in the up position. She states that resident was confused, but that was not her patient. In an interview with LPN BB on 03/26/2026 at 1:24 PM admits that side rails are used for R12 because she has confusing and for her safety. The use of four rails are used when no one is at bedside. 2.Review of Face Sheet revealed that R40 was admitted on [DATE] for a diagnosis tension pneumothorax. Review of the Five-Day Minimum Data Set (MDS) for R40, dated 03/24/2026, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 12 (indication moderate cognitive impairment). Section GG (Functional Abilities and Goals) documented that the resident required supervision or touch assistance for sit to lying, sit to stand, and chair to bed transfer. The documentation revealed that rolling left to right and lying to sitting was not attempted due to medical condition or safety. Review of the physician orders for R40 revealed no order for bilateral upper and lower bed rails. Review of record for R40 revealed no (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed rail assessment. Review of Consent Form for Protective Devices dated 03/18/2026 for R40 documented the use of two side rails was recommended equipment. Observation on 03/25/2026 at 8:05AM revealed that R40 had two upper rails and left lower bed rail in the up position on the bed. Observation on 03/25/2026 at 3:55 PM revealed that R40 had two upper rails and left lower bed rail in the up position on the bed. Observation on 03/26/2026 at 8:25 AM revealed that R40 had bilateral upper and lower bed rails in the up position on the bed. He states he tries to move around in the bed. He states they usually have all the bedrails up. Observation and Interview with LPN BB on 03/26/2026 at 11:03 AM revealed that resident had four bed rails up. She states that the residents sign paperwork for bedrails. She reports that anyone that comes in signs the bed rail form. She states that four bed rails are not considered a restraint. Anytime the resident wants the rail down they can have the rail down. 3.Review of Face Sheet revealed that R41 was admitted on [DATE] status post a closed femur fracture repair. Review of the Five-Day Minimum Data Set (MDS) for R41, dated 03/19/2026, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 11 (indication moderate cognitive impairment). Section GG (Functional Abilities and Goals) documented that the resident required partial to moderate assistance for lying to sitting, sitting to stand, and toilet transfers. The documentation revealed that rolling left to right and sitting to lying was not attempted due to medical condition or safety. Review of the physician orders for R41 revealed no order for bilateral upper and lower bed rails. Review of record for R41 revealed no bed rail assessment. Review of Consent Form for Protective Devices dated 03/19/2026 for R40 documented the use of side rail use was equipment recommendation for positioning and mobility device. Observation on 03/25/2026 at 8:20 AM revealed that R41 had bilateral upper and lower bed rails were in the up position on the bed. Observation on 03/25/2026 at 4:05 PM revealed that R41 had bilateral upper and lower bed rails were in the up position on the bed. Observation on 03/26/2026 at 10:52 AM revealed that R41 had bilateral upper and lower bed rails were in the up position on the bed. Observation and Interview on 03/26/2026 at 11:10 AM with LPN CC confirmed that R41 had bilateral upper and lower bedrails in the up position. She reported that R41 was at risk for falls. She states that the rails are used to prevent falls. LPN CC was unsure if the resident had consent in place. Interview with Director of Nursing (DON) on 03/26/2026 at 11:25 AM revealed that consent forms are obtained for the use of bed rails. She confirmed that there are no orders for bed rails or bed rail assessments for R12, R40, and R41. The only assessments that are completed by the facility is skin assessment and fall risk assessment. This is what is used throughout the healthcare system. She confirmed that R40 was consented for two bed rails. The more of two rails can be verbally consented by the resident or residents' family. She confirmed that bilateral upper and lower bed rails in up position on the bed is considered a restraint.

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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 reviews, and review of facility policies Isolation Categories, Central Venous Catheters, and Hand Hygiene), the facility did not ensure that nurses consistently followed infectionˆcontrol practices during peripheral venous catheter infusions for two residents(R) (R12, R50), peripheral catheter care for one (R) (R12), wound care for one (R) (R39), and bedˆlinen handling for two (R) (R9, R12). These practices created the potential risk for infection due to contamination. Findings Include:Review of the facility's policy titled, Isolation Categories, dated 8/8/2023, section I. Standard Precautions revealed that A. Purpose: To prevent the transmission of infections which are spread by direct or indirect contact with infective blood or body fluids.3. Requirements: b. Handwashing with an antimicrobial soap or hand sanitizing with an alcohol based handrub must be performed before and after glove use, before and after touching the patient and or potentially contaminated articles, before leaving the room, and before taking care of another patient.c. A cover gown is required if contamination of clothing with blood or body fluid is likely/can be anticipated. Review of the facility's policy titled, Central Venous Catheters, dated 5/28/2025, the Policy Statement revealed that It shall be the policy of [Facility Name] to care for patients needing central venous access including single, multi-lumen, or large bore catheters and maintain the catheters for patients who have them. D. Dressing Change: Note: A second caregiver (nurse or PCT) must be present to assist with maintaining a sterile field. Review of facility's policy titled, Hand Hygiene, dated 9/26/2025, the Policy Statement revealed that It shall be the be the policy of [Facility Name] to reduce the risk fo spread of infection among co-workers and patient populations. [Facility Name] recognizes that proper hand hygiene is the single most effective means of preenting and controlling the spread of infection. Section Procedures revealed that B. Indications for use of Alochol-Based Hand Rub:.1.Upon entering room, 2. Before having direct contact with patients, 3. Before inserting devices, 4. After contact with patient's intact skin, 5. After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings, only if hands are not visibly soiled, 6. When moving from a contaminated body site to a clean body site during patient care, 8. Gloves are not a replacement for hand hygiene. Hands will be washed or alcohol-based hand rub used immediately before and immediately after wearing gloves.Review of the Face Sheet revealed that R12 was admitted on [DATE] for a diagnosis of acute kidney injury on chronic kidney injury.Review of Five Day Scheduled Minimum Data Set (MDS) for R12, dated 03/18/2026, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 6 (indicating severe cognitive impairment). Section GG (Functional Abilities and Goals) documented that the resident required partial to moderate assistance for activities of daily living (ADL) Section I (Active Diagnosis) revealed diagnosis of but not all-inclusive non-Alzheimer's dementia, acute kidney failure (AKF), Hypertension (HTN), chronic kidney disease (CKD), and atrial fibrillation. Section O (Special Treatments, Procedures, and Programs) revealed that residents were receiving intravenous (IV) medications and antibiotics.Review of the care plan for R12, dated 03/14/2026, revealed a focus are that resident has an infection of sepsis. Interventions included administering medications as per physician's order, monitor for signs and symptom's adverse reactions to medications, reporting signs and symptoms of worsening infection to resident's physician and hospice, and determine resident/family wishes regarding antibiotic interventions.Review of the physician orders revealed that R12 had an order for meropenem [IV antibiotic] 500 mg {milligrams} administered intravenously every 12 hours. Sodium chloride 0.9 percent flush ten mg intravenously three times a day at 4:00AM, 12:00 PM, 8:00 PM. Observation on 03/25/2026 at 10:12 AM revealed that Licensed Practical Nurse (LPN) FF revealed that her hands were clean upon entering room and applied gloves. She was not wearing a gown. She prepared the Meropenem (IV antibiotic) by priming the IV line. She cleaned hand and changed gloves. She cleaned the line, flushed the line, and drew back blood. She connected the IV (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antibiotic to the resident's peripheral inserted central catheter (PICC) in the right arm. She then started the IV pump.Interview with LPN FF on 03/25/2026 at 2:53 PM revealed that she was not wearing a gown during the IV infusion. She states that R12 was not under enhanced barrier precautions. She states she is under standard precautions. She states a gown was not necessary only if pulling out the line.Observation on 03/25/2026 at 4:44 PM with the Director of Nursing (DON) and LPN FF revealed that supplies were prepared. The DON and LPN FF were not wearing gowns. The DON performed hand hygiene and applied gloves. She used an alcohol wipe along the edge of the dressing. She then applied sterile gloves from the central dressing kit. She removed the dressing and the Biopatch with the sterile gloves. The same gloves used to remove the dressing and Biopatch were then used to remove gray gloves from the box on the wall, and she applied the new gloves. She cleaned the area with an alcohol swab, followed by a chlorhexidine swab using a backˆandˆforth motion. She removed her gloves and sanitized her hands. She applied a new pair of gray gloves from the box on the wall, placed the Biopatch around the line, applied a stabilizer to the arm, connected the PICC line to the stabilizer, and applied the sterile dressing on top.Interview on 03/25/2026 at 5:04 PM with the DON confirmed that she used the sterile gloves to remove the dressing. She admits that she should have had the other nurse obtain another pair of sterile gloves. She admits that she used up and down motion to clean the site. She confirmed that cleaning a PICC line site after removing the dressing was a sterile procedure. She admits that she was not wearing a gown during the procedure. Record Review revealed that R50 was admitted on [DATE] with a diagnosis of obstructive uropathy, leiomyosarcoma, chronic malnutrition on TPN (Total Parental Nutrition) with PEG (percutaneous endoscopic gastrostomy) feeding tube, urine foley catheter in place, and peripheral venous catheter to the left arm. Review of physician orders dated 03/25/2026 revealed an order Fluconazole (antifungal) 400 mg (milligrams) intravenously every 24 hours.Observation on 03/25/2026 at 10:30 AM revealed Registered Nurse (RN) DD revealed that she did not wear a gown during the care provided to residents. RDDD connected the IV line after cleaning the site and started the infusion.Interview on 03/25/2026 at 1:51 PM with RN DD revealed that she had not been wearing a gown during the administration of R50's antifungal infusion. She stated that she had never been instructed to wear a gown for this task. RN DD reported that residents were placed under standard precautions, which, according to her understanding, required the use of gloves.Observation on 03/25/2026 at 11:17 AM of RN DD complete wound care of R 39. She had supplies set up in room on bedside table. She was not wearing a gown. She had medication cart in room. RN DD sanitized hand and applied gloves. She then removed dressing to the right calf, left ankle and left calf. She did not sanitize or change gloves. She cleaned wound with half strength Dakin's (wound cleaner). She then applied Santyl gel to the wound straight from the tube. She laid the tube down on the pad under resident between the two wounds. She then removed gloves. She touched the silver alginate with bear hands to cut out a piece for the wound. RN DD did not sanitize hands prior to applying gloves then applied foam dressing to the right calf. She proceeded to address the left ankle by removing her gloves but did not sanitize hands. She cleaned wound with half strength Dakin's (wound cleaner). She removed gloves and did not sanitize. She then cut with bear hands a silver alginate then donned a new pair of gloves without sanitizing hands. She then applied outer foam dressing. Finally, RN DD cleaned hands and applied new gloves. She cleaned the small wounds to the left calf with 0.9 percent sodium chloride. She changed gloves but did not sanitize before the application of the xeroform and foam dressing.Interview on 03/25/2026 at 2:42 PM, RN DD stated that she had not been wearing a gown because the resident was under standard precautions. She acknowledged that, when removing a dressing, hand hygiene should be performed and gloves should be changed. She reported, I knew what I was supposed to do, but I knew I did not do everything correctly. RD DD confirmed that the Santyl gel and scissors had been placed on the field during the dressing change. She also admitted that she placed the tube back into the bag without cleaning it.Observation on 03/25/2026 at 2:04 PM of Wound Care Nurse (WCN) EE revealed that she was not wearing a gown while providing colostomy care to R9. WCN EE was observed using (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scissors taken from her pocket to cut off the resident's brief. She then placed the scissors back into her left scrub pocket without cleaning them. WCN EE exited the room while still wearing gloves to obtain additional colostomy supplies. After completing the ostomy care, she proceeded to change R9 because the colostomy had leaked onto the bed and the resident's gown. She was observed leaning against the bed in her scrubs while removing the top sheet and R9's gown. She placed the top sheet, gown, and the towel used to clean around the colostomy on the floor. Further observation revealed RN DD entered the room without a gown. She sanitized her hands and applied gloves. RN DD rolled the fecesˆsoiled linen under R9 and then tucked clean linens underneath the soiled linens. She placed the fecesˆsoiled fitted sheet into the trash can located in the room. WCN EE then exited the room.Interview on 3/25/2026 at 2:34 PM with WCN EE confirmed that she did not disinfect scissors and admits that they need to be cleaned. She admits that she was not wearing a gown because the resident was under standard precautions. She admitted she should not wear used gloves outside of the room. She confirmed that linens were placed on the floor. She reports that the process is to put the linen in the linen bag in the nursing pod. She was told she could not bring bags into the room. She states that each pod has a linen cart. The nurse must come out of the room with the dirty linen.A concurrent observation and interview on 03/26/2026 at 11:15 AM revealed Certified Nursing Assistant (CNA) GG existing the room of R12 carrying dirty linens. A meal tray was observed placed on top of the soiledˆlinen hamper, and CNA GG asked the nurse to move the tray. The dirty linens were observed in direct contact with the CNA's scrubs. She lifted the hamper lid and placed the linens inside. CNA GG acknowledged that linens should not come into contact with her clothing. She also stated that there had not been a linen bag in the resident's room. She reported that she had placed the dirty linens on the bedside commode in the room until she completed the bed change.Interview on 3/25/2026 at 3:40 PM with DON revealed that the facility uses the health system policy of universal precautions. The enhanced barrier precautions were standard precautions, which were gloves and good handwashing. The nurse would glove and sanitize when changing the dressing to adding a new dressing, but gown was not needed. Good hand washing when entering and exiting a room. Gowns are not needed during wound care, IV infusion, bath or changing a colostomy. A concurrent interview with Infection Preventionist (IP) HH and IP II revealed that the facility followed the Five Moments for Hand Hygiene, which included removing gloves and performing hand hygiene when transitioning from dirty to clean tasks. IP II stated that a nurse should sanitize hands-unless visibly soiled-and apply a new pair of gloves after removing a dressing or when moving to another body part. IP HH stated that the facility used standard precautions. IP II confirmed that the facility did not use enhanced barrier precautions and that the unit was treated the same as any other unit within the health system. They reported that if linens were soiled with bodily fluids, staff were expected to wear appropriate PPE, including a gown. They further stated that dirty linens, even when not visibly soiled, should not be held against CNA's or nurse's scrubs. Both IPs confirmed that soiled linens should not be placed on the floor. The expectation was that staff would take the linens outside the resident's room to the linen cart and place them in the cart before completing the bed change. They also stated that a central line dressing change was a sterile procedure, but wearing a gown was not required.