

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2025
NAME OF PROVIDER OR SUPPLIER Wynfield Park Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 223 W.Third Avenue Albany, GA 31701	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation, interview, record review, and review of the facility policy titled, Meal Service, the facility failed to provide a dignified dining experience for one of five residents (R)(R45) by standing instead of sitting next to the resident while assisting him during a meal. This failure had the potential to have a negative impact on the quality of life and self-esteem for the affected resident.</p> <p>Findings include:</p> <p>A review of the facility policy titled, Meal Service dated 12/27/24 indicated Associates should promote and maintain patients' dignity and respect during meal service.</p> <p>During a meal observation on 06/17/25 at 12:50 PM, Registered Nurse (RN) 7 was observed standing next to R45 while assisting him with the meal. RN 7 was observed to be watching other activities in the dining room and not interacting with R45.</p> <p>During an interview on 06/17/25 at 1:17 PM, RN 7 stated she had not received any training in dining room protocol. RN7 stated she knew she should be sitting down and interacting with R45 while assisting him, but she did not like to sit. RN 7 agreed that sitting with a resident while assisting them was more dignified and respectful.</p> <p>During an interview on 06/19/25 at 10:27 AM, the Assistant Dietary Manager (ADM) stated that all staff should know that they should sit next to a resident while assisting them. The ADM agreed that standing above a resident while assisting them is not dignified and sitting next to a resident and encouraging them and interacting with them during the meal is the correct way to assist during mealtime.</p> <p>During an interview on 06/20/25 at 10:27 AM, the Dietary Manager (DM) stated that he expected staff to provide a calm and dignified dining experience. The DM stated that standing while assisting a resident was not appropriate and staff should sit at eye level and interact with the resident on a dignified and personal level.</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review, the facility failed to protect four of four male residents (R) (R127, R12, R105, and R106) right to be free from sexual abuse by R147. Specifically, the facility failed to protect R127, R12, R105, and R106 from R147s' known inappropriate hypersexual behaviors.</p> <p>Findings include:</p> <p>Review of R147's electronic medical record (EMR), Face Sheet tab, revealed she was admitted on [DATE] with diagnosis that included Encephalopathy, Restlessness and agitation, Disorientation, Delayed milestone in childhood, Unspecified disorder of psychological development, and anxiety disorder.</p> <p>Review of R147's EMR, Social Services tab, revealed a Resident Social Assessment, dated 03/24/25, documented R147's Family Member (FM)1 reported R147 had a known history of sexually inappropriate behaviors towards men.</p> <p>Review of R147's EMR, Minimum Data Set (MDS) tab, admission MDS with an Assessment Reference Date (ARD) of 03/24/25, indicated R147 had a Brief Interview for Mental Status (BIMS) score of 10 of 15 indicating moderately impaired cognition.</p> <p>Review of 147's EMR, Care Plan tab, revealed an initial care plan meeting dated 03/24/25, where during the initial care plan conference for R147 FM1 informed the staff that R147 had a history of inappropriate sexual impulses, did not want R147 to be allowed to enter the rooms of male residents, and requested male staff did not provide her care. No care plan was developed to alert staff to her hypersexual behaviors.</p> <p>Review of the EMR, Nursing Progress Notes tab, revealed Registered Nurse (RN)1 documented on 03/31/25 that a staff member (name unknown) observed R147 in the room of R127, lying on top of R127 in his bed, kissing him, and touching his face. R147 was removed from R127's room and placed on 15-minute monitoring checks for 24 hours following the incident. The incident was reported and investigated within the time frames to the State Agency.</p> <p>Review of the EMR, MDS tab revealed MDS an ARD of 04/02/25, that indicated R127 had a BIMS score of four of 15 indicating severe cognitive impairment.</p> <p>Review of the EMR, Scanned Documents tab revealed a Psychiatric Diagnostic Evaluation completed by Medical Doctor (MD)1 on 04/21/25 documented R147 had a baseline impulsive behavior closely monitored by FM1 over many years as reported to the facility upon admission as being flirtatious and impulsive. The evaluation documented that Early on in the nursing home, she was found to be having sexual relationships with men, and poor boundaries. MD1 recommended a personal care home with extensive redirection and training while in the nursing facility. MD1 initiated the administration of Depakote for sexually inappropriate behavior.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the EMR, Nursing Progress Notes tab, progress notes, on 05/28/25 a staff member (name unknown) on the third floor of the facility reported to Licensed Practical Nurse (LPN)1 that R147 was observed slapping R12 on the thigh/groin area of the leg. At the time of the incident, R12 had a BIMS of four indicating severe cognitive impairment. The incident was investigated and reported to the State Agency within two hours. R147 was immediately transferred to the fourth floor in the facility and 15-minute monitoring was initiated for R147.</p> <p>Review of the EMR, Nursing Progress Notes tab, progress notes dated 05/28/25, RN2 documented that within 30 minutes of R147's placement on the fourth floor, she was observed in the room of R106 and sitting in his lap stroking his face. R106 had a BIMS of three of 15, indicating moderate cognitive impairment. R147 was redirected out of R106's room and was then observed in the room of R105, stroking and rubbing his face. R105 had a BIMS of seven of 15 indicating moderate cognitive impairment. Documentation indicated R147 was redirected out of the resident's room.</p> <p>Review of the EMR, Scanned Documents tab, revealed a Psychiatric consult conducted on 05/30/25, documented that due to her [R147] known hypersexual behavior (which can escalate her physical aggressiveness, the MD1 supported the intervention of maintaining physical separation of R147 from the male residents.</p> <p>During an interview on 06/17/25 at 3:30 PM, the Administrator stated the two incidents that occurred on the fourth floor on 05/28/25 were not investigated or reported to the state agency because the incidents indicated no harm, that the behavior was consensual, and that R106 and R105 were not bothered by the behavior of R147. The Administrator was asked how the men were assessed to determine that the behavior was consensual and caused no harm. The Administrator replied she had no rationale other than she was told by a staff member that it was consensual.</p> <p>During an interview on 06/18/25 at 9:20 AM, Certified Nursing Assistant (CNA)1, stated she had not been informed of the sexual behaviors of R147 and had not been provided education on any interventions to prevent the behaviors or to provide increased supervision for R147. CNA1 said she would consider R147's behaviors to be sexual abuse and would immediately report the incident to the Administrator/Abuse Coordinator. She stated that she provided care for R105 and that he was soft spoken and would be bothered if/when R147 stroked or rubbed his face but that he would not report his concern to anyone.</p> <p>During an interview with CNA2 on 06/18/25 at 9:30 AM, she stated she had not been informed of the sexual behaviors and had not been provided education on any interventions to prevent or to provide increased supervision for R147. She said she would consider R147's behaviors to be sexual abuse and would immediately report the incident to the Administrator/Abuse Coordinator She stated that she provided care for R105 and that he would be bothered if/when R147 stroked or rubbed him but was very soft spoken and would not report his concern to anyone.</p> <p>During an interview on 06/18/25 at 9:45 AM, the Social Services Director (SSD)1 stated she had not been informed about the hypersexual behaviors or the inappropriate behaviors of R147 that occurred on 05/28/25 on the fourth floor.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview by phone on 06/18/25 at 2:30 PM with RN2, revealed she did not recognize the 05/28/25 fourth floor incident as abuse. She stated it did not seem to her at the time that sitting in a residents' lap or stroking another resident's face was sexual abuse in nature and did not think of interviewing the residents to determine if it was consensual or if any harm had occurred. She said she did not witness the incident, and she could not remember the staff member that reported the observations to her. RN2 said she documented the incident in the progress notes in case something came up about it later. She said she had not been informed that R147 had a history of inappropriate sexual behaviors.</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility policy titled, Restraints, the facility failed to ensure one of one Resident (R) (R102) reviewed for physical restraints was not physically restrained by being in bed with a Geri-chair and a regular chair placed up against her bed, blocking her ability to get out of her bed on one side.</p> <p>Findings include:</p> <p>Review of the facility policy titled, Restraints dated 12/27/24 indicated .It is the intent of this center that patients have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the patient's medical symptoms.Prior to use of a restraint, the following should be completed.Patient's need for restraint assessed.Restraint consent.</p> <p>Review of R102's electronic medical record (EMR) titled Face Sheet located under the Resident file tab indicated the resident was admitted to the facility on [DATE].</p> <p>Review of R102's EMR titled quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/09/25 located under the survey shell, indicated the resident had a Brief Interview for Mental Status (BIMS) score of two out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident had an impairment on one side of her lower extremity. The assessment indicated R102 required substantial to maximum assistance from a caregiver to do activities of daily living. The assessment revealed the resident had one fall since her most recent admission.</p> <p>Review of a document provided by the facility titled Care Plan for R102 dated 01/27/25 indicated R102 had poor decision making. There was no evidence in the care plan that indicated the resident required the use of a potential restraint.</p> <p>An observation conducted on 06/17/25 at 7:35 AM, revealed R102 in bed. Facing the resident's bed from the entry to her room, a Geri-chair and a regular chair were observed next to her bed which blocked her ability to get out of bed. The resident was observed again in the same place on 06/17/25 at 7:49 AM.</p> <p>During an interview on 06/17/25 at 7:58 AM, Registered Nurse (RN)1 who was also the second floor's wound nurse stated that she considered the placement of the Geri-chair and regular chair a potential restraint since the resident was blocked in.</p> <p>During an interview on 06/17/25 at 8:00 AM, Certified Nurse Aide (CNA) 1 stated that the CNAs use the Geri -chair and regular chair pushed up against R102's bed to prevent the resident from climbing out of bed and did not report it as a potential restraint.</p> <p>During an interview on 06/17/25 at 8:04 AM, CNA 2 confirmed the observation of R102's Geri-chair and regular chair pushed up against the side of her bed. CNA2 stated R102 was a fall risk and stated this was what she observed when she arrives in the morning.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/17/25 at 8:06 AM, the Administrator confirmed the observation of the Geri -chair, and the regular chair pushed against R102's bed. The Administrator moved the regular chair and Geri -chair to the front of the resident's room.</p> <p>During an interview on 06/17/25 at 2:13 PM, the Health Information Manager (HIM) confirmed she enters R102's room, every week or two, to ensure R102's room was clean and to make sure things were in place. The HIM stated she had previously moved the resident's Geri -chair, away from R102's side of her bed, since it blocked one side of the resident's bed and the resident was unable to reach her water. The HIM stated she had this observation a few times and reminded the clinical staff, during the morning meetings, to remove the Geri -chair from the resident's side of her bed. When asked if she considered the Geri -chair pushed up against the resident's bed a potential restraint, the HIM stated it was odd.</p> <p>During an interview on 06/17/25 at 3:01 PM, CNA3 confirmed she had observed R102's Geri -chair pushed up against the resident's bed. CNA3 stated she considered the Geri -chair pushed up against the resident's bed a potential restraint.</p> <p>During an interview on 06/18/25 at 3:39 PM, the Director of Nursing (DON) stated that she has never seen the Geri-chair pushed up against R102's bed and her expectation was for the CNAs to alert the nurses on duty of this observation.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility policy titled, Abuse Prohibition-Reporting and Investigating, the facility failed to report allegations of sexual abuse for two of four male residents (R) (R106, and R107) reviewed for abuse related to R147's inappropriate hypersexual behaviors.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Abuse Prohibition-Reporting and Investigating, dated 12/27/24, revealed All allegations of abuse or allegations involving serious bodily injury must be reported immediately but no later than 2 hours.</p> <p>Review of R147's electronic medical record (EMR), Face Sheet tab, revealed she was admitted on [DATE] with diagnosis that included encephalopathy, restlessness and agitation, disorientation, delayed milestone in childhood, unspecified disorder of psychological development, and anxiety disorder.</p> <p>Review of R147's EMR, Social Services tab, revealed a Resident Social Assessment, dated 03/24/25, documented R147's Family Member (FM)1 reported R147 had a known history of sexually inappropriate behaviors towards men.</p> <p>Review of R147's EMR, Minimum Data Set (MDS) tab, admission MDS with an Assessment Reference Date (ARD) of 03/24/25, indicated R147 had a Brief Interview for Mental Status (BIMS) score of 10 of 15 indicating moderately impaired cognition.</p> <p>Review of the EMR, MDS tab revealed an MDS an ARD of 04/02/25, that indicated R127 had a BIMS score of four of 15 indicating severe cognitive impairment.</p> <p>Review of R106's MDS with an ARD of 4/14/25, revealed he had a BIMS score of three out of 15 which indicated he was severely cognitively impaired and unable to consent.</p> <p>Review of R105's MDS with an ARD of 4/7/25, revealed he had a BIMS score of seven out of 15 which indicated he was severely cognitively impaired and unable to consent.</p> <p>During an interview on 06/17/25 at 3:30 PM, the Administrator stated the 05/28/25 incidents were reported to her by RN2 but was not reported to the State Agency because the incident was not recognized as sexual abuse, indicated no harm, that it was consensual, and that R106 and R105 were not bothered by the behavior of R147. The Administrator was asked how the men were assessed to determine that the behavior was consensual; she had no rationale other than she was told by staff that it was consensual. She did not know the name of the staff member that observed the incidents.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review, and review of the facility's policy titled, Abuse Prohibition-Reporting and Investigating, the facility failed to investigate allegations of abuse for two of four male residents (R) (R106, and R107) related to R147's known inappropriate hypersexual behaviors. The facility failed to identify and investigate allegations of resident-to-resident sexual abuse after resident R147 was observed in R106's room and sitting on R106's lap and then stroking and rubbing R105's face. This failure had the potential for additional male residents to be sexually abused by R147.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Abuse Prohibition-Reporting and Investigating, dated 12/27/24, revealed . Center will respond immediately to protect the alleged victim and integrity of the investigation. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed. Increased supervision of the alleged victim and residents.</p> <p>Review of R147's electronic medical record (EMR) revealed she was admitted on [DATE] with diagnosis that included encephalopathy, restlessness and agitation, disorientation, delayed milestone in childhood, unspecified disorder of psychological development, anxiety disorder.</p> <p>Review of R147's EMR, Social Services tab, revealed a Resident Social Assessment, dated 03/24/25, that documented R147 had a known history of sexually inappropriate behaviors towards men per the Family Member (FM) 1.</p> <p>Review of R147's 5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/27/25 revealed a Brief Interview for Mental Status (BIMS) score of ten out of 15 which indicated moderate cognitive impairment.</p> <p>Review of the EMR, Nursing Progress Notes tab, revealed progress notes dated 05/28/25, that RN2 documented that within 30 minutes of R147's placement on the fourth floor, she was observed in the room of R106 and sitting in his lap. R147 was redirected out of R106's room and was then observed in R105's room stroking and rubbing his face. Documentation indicated she was redirected out of the resident room.</p> <p>Review of R106's MDS with an ARD of 4/14/25, revealed he had a BIMS score of three out of 15 which indicated he was severely cognitively impaired and unable to consent.</p> <p>Review of R105's MDS with an ARD of 4/7/25, revealed he had a BIMS score of seven out of 15 which indicated he was severely cognitively impaired and unable to consent.</p> <p>During an interview on 06/17/25 at 3:30 PM, h the Administrator stated the 05/28/25 incidents were not investigated because the incident indicated no harm, that it was consensual, and that R106 and R105 were not bothered by the behavior of R147. The Administrator was asked how the men were assessed to determine that the behavior was consensual, but she had no rationale other than she was told by staff that it was consensual.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/18/25 at 2:30 PM with Registered Nurse (RN)2, she did not recognize the incident as abuse. She stated it did not seem to her at the time that sitting in a resident's lap or stroking another resident's face was sexual abuse in nature and did not think of interviewing the residents to determine if it was consensual or if any harm had occurred. RN2 said she only documented the incident in the progress notes in case something came up about it later.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility policy titled, Patient's Plan of Care, the facility failed to develop a comprehensive care plan directing measurable goals and interventions for one of 36 residents Resident(R) (R1). This failure placed R1 at risk for unmet care needs and the inability to meet their maximum practicable level of functioning.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Patient's Plan of Care, reviewed date 12/27/24, revealed Intent: To promote person-centered patient care through a comprehensive care plan .Each patient will have a person-centered comprehensive care plan developed and implemented to address the patients' medical, physical, mental, and psychosocial needs while also honoring their preferences and goals.</p> <p>Review of R1's undated Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab indicated the resident was admitted to the facility on [DATE] with diagnoses including quadriplegia, aphasia following nontraumatic intracranial hemorrhage, and dysphagia following cerebrovascular disease.</p> <p>Review of R1's quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 05/21/25, located in the EMR under the MDS tab, Staff Assessment for Mental Status revealed R1 is severely cognitively impaired, and was receiving restorative nursing for splint or brace assistance.</p> <p>Review of R1's Care Plan dated 03/28/24, located in the EMR under the Care Plan tab revealed Range of motion limited-at risk for/actual contractures related to neck flexion contracture, as evidenced by contractures, with interventions including assistance with activities of daily living (ADLs) as needed, provide appropriate level of assistance to promote safety of the resident. There was no documentation related to the neck pillow in the R1's care plan.</p> <p>During an interview with the Director of Nursing on 06/18/25 at 11:36 AM, DON was questioned concerning R1's neck pillow and what was expected from the staff. DON replied that unless the resident refuses, she would expect the staff to follow the orders and care plan, and to document if the resident refuses. DON additionally confirmed that the resident had been care planned for his contracted neck, but the interventions did not include the use of the neck pillow/support as ordered.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and document review, the facility failed to ensure one of eight Resident(R) (R1) reviewed for range of motion (ROM) received the equipment to prevent further decrease of motion. This has the potential to cause further decreases in motion and discomfort.</p> <p>Findings include:</p> <p>Policies were requested but not provided by facility.</p> <p>Review of R1's undated Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab indicated the resident was admitted to the facility on [DATE] with diagnoses including quadriplegia, aphasia following nontraumatic intracranial hemorrhage, and dysphagia following cerebrovascular disease.</p> <p>Review of R1's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 05/21/25, located in the EMR under the MDS tab, Staff Assessment for Mental Status revealed R1 is severely cognitively impaired, and was receiving restorative nursing for splint or brace assistance.</p> <p>Review of R1's Physician Orders dated 03/03/25, located in the EMR under the Orders tab revealed an order to apply neck pillow for head support.</p> <p>Review of R1's Care Plan dated 03/28/24, located in the EMR under the Care Plan tab revealed Range of motion limited-at risk for/actual contractures related to neck flexion contracture, as evidenced by contractures, with interventions including assistance with activities of daily living (ADLs) as needed, provide appropriate level of assistance to promote safety of the resident. There was no documentation related to the neck pillow in the R1's care plan.</p> <p>During observations conducted on 06/17/25 at 8:15 AM, 11:00 AM, 4:00 PM, and on 06/18/25 at 9:05 AM, R1 was observed without the neck pillow in place. R1's neck was contracted and tilted to his right-side. During an observation conducted on 06/18/25 at 9:05AM of R1's room, there was no neck pillow located in the resident's room.</p> <p>During an interview on 06/18/25 at 11:33 AM, Registered Nurse (RN)9, was asked if R1 uses a support for his contracted neck. RN9 replied, Yes, he is supposed to have a neck pillow for support.</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 06/18/25 11:34 AM, the ADON was asked what the expectations are related to R1's neck pillow/brace. ADON replied, I would expect the staff to follow the physician orders and care.</p> <p>During an interview with the Director of Nursing on 06/18/25 at 11:36AM, DON was questioned concerning R1's neck pillow and what is expected from the staff. DON replied that unless the resident refuses, she would expect the staff to follow the orders and care plan, and to document if the resident refuses.</p>		

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NAME OF PROVIDER OR SUPPLIER Wynfield Park Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 223 W.Third Avenue Albany, GA 31701	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and review of the facility policy titled, Fall Management, the facility failed to properly assess one of four Residents (R) (R45) for the use of a Geri-chair. The use of a Geri-chair without a proper therapy assessment created the potential for R45 to sustain falls with potential injuries.</p> <p>Findings include:</p> <p>Review of a facility policy titled, Fall Management dated 12/27/24 indicated .Each patient is assisted in attaining/maintaining his or her highest practicable level of function by providing the patient adequate supervision, assistive devices and/or functional programs as appropriate to minimize the risk for falls. Each patient's risk for falls is evaluated on admission, readmission, quarterly, annually, with a significant change in condition, and as indicated.A plan of care is developed and implemented based on this evaluation with ongoing review. If a fall occurs, an evaluation is completed to ensure appropriate measures are in place to minimize the risk of future falls. The IDT is responsible for coordination of an interdisciplinary approach to managing the processes for prediction, risk assessment, treatment, evaluation, monitoring, and calculation of patient falls.</p> <p>Review of a document provided by the facility for R45 titled, Face Sheet indicated the resident was admitted to the facility on [DATE] with a diagnosis of Myasthenia gravis (an autoimmune disease which affects a person's neurological system).</p> <p>Review of R45's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/09/25 located in the survey shell indicated the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which revealed the resident was moderately cognitively impaired. The assessment indicated the resident had no bi-lateral upper and lower body impairments. The assessment indicated R45 required partial to moderate assistance from sitting to standing.</p> <p>Review of a document provided by the facility titled Comprehensive Nursing Assessment dated 10/09/24 indicated the functional status of the resident was identified with an unsteady gait, required assistance from moving from sitting to lying position, and the same from standing to sitting. This document was provided upon request for a fall risk assessment.</p> <p>Review of a document provided by the facility titled, Comprehensive Nursing Assessment dated 11/16/24 indicated the functional status of the resident was the resident was identified with an unsteady gait, required assistance from moving from sitting to lying position, and the same from standing to sitting. This document was provided upon request for a fall risk assessment.</p> <p>Review of a document provided by the facility titled, Comprehensive Nursing Assessment dated 04/17/25 indicated the functional status of the resident was the resident was identified with an unsteady gait, required assistance from moving from sitting to lying position, and the same from standing to sitting. This document was provided upon request for a fall risk assessment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a document provided by the facility titled, Care Plan dated 06/03/25 indicated the resident had a diagnosis of Myasthenia gravis and was at higher risk for falls. Specifically, the resident continued to be independent, but the range of motion was unsteady. There was no evidence in the care plan that identified the residents' use of a Geri-chair as a fall prevention measure.</p> <p>During an interview on 06/16/25 at 9:59 AM, R45's Family Member (FM)2 stated the resident falls almost daily. FM2 stated the resident had a diagnosis of Myasthenia gravis, and he was aware that the resident would continue to fall and to decline as a result. The resident was sitting in a Geri-chair during this interview. Fm2 stated he was unaware how long the resident used a Geri-chair. During this interview, the resident attempted to get out of the Geri-chair but FM2 was able to redirect back. At 10:49 AM, R45 was in the main television room, across from the nursing station. The resident did not attempt to get up from the Geri-chair. At 11:44 AM the resident was sitting in a regular wheelchair.</p> <p>During an interview on 06/17/25 at 8:23 AM, Certified Nurse Aide (CNA) 12 stated that she observed R45 in a Geri -chair on 06/16/25 and stated the resident was sitting in the Geri-chair when she arrived for work and stated the resident was a fall risk.</p> <p>During an interview on 06/17/25 at 8:02 AM CNA1 stated she observed R45 sitting in the Geri -chair on 06/16/25 and has seen the resident sitting in his Geri-chair for the past week.</p> <p>During an interview on 06/18/25 at 11:34 AM, the Director of Rehabilitation (DOR) stated it was anticipated that R45 would decline. The DOR stated she has been involved in his care to assist him with strength. The DOR stated that therapy will assess the resident for the use of a Geri -chair and the resident would only be placed in a Geri-chair for positioning and stated it might be a potential accident hazard. The DOR stated the resident does stand and she would not recommend a Geri-chair for a resident who stands.</p> <p>During an interview on 06/18/25 at 11:53 AM, Registered Nurse (RN)4 who was also the second-floor supervisor stated that therapy normally takes the lead in assessing the resident for a Geri-chair. RN4 stated R45 was in the Geri-chair on 06/16/25 when she arrived for work. RN4 stated that R45 was a high risk for falls and the use of a Geri-chair would place the resident at risk of injury.</p> <p>During an interview on 06/18/25 at 12:53 PM, the Administrator stated that therapy must assess a resident first prior to the use of a Geri-chair.</p> <p>During an interview on 06/18/25 at 3:45 PM, the Director of Nursing (DON) was asked if there was a therapy assessment. The DON stated it was a judgment call from the nurse to determine if R45 needed to be placed in the Geri-chair for comfort. The DON stated she believed that R45 transferred himself.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and document review, the facility failed to ensure one of one Resident (R) (R1) urinalysis was completed timely. This had the potential to delay the resident's treatment of abnormal laboratory results.</p> <p>Findings include:</p> <p>Policies were requested but not provided by the facility.</p> <p>Review of R71's undated Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab, indicated the resident was admitted to the facility on [DATE], and discharged [DATE] with diagnoses including dementia with other behavioral disturbance.</p> <p>Review of the R71's Grievance dated 05/07/25, provided by the facility, revealed During 5/8 follow-up discussion the following additional concerns were voiced-Registered Nurse [(RN)6] received an order for urinalysis (UA), but did not follow through .Actions taken: RN6 confirmed she received the UA order but failed to enter .Order was entered 05/08/25 and taken to the hospital for stat processing. Results received were negative for findings. Interview with nurse is not able to determine details around who told her and when.</p> <p>Review of the facility's document titled Corrective Action Improvement Plan dated 05/08/25, revealed RN6 discussed with family getting a UA. Reached out to Nurse Practitioner (NP), who gave orders, however, RN6 did not enter order. This resulted in non-compliance with physician orders.</p> <p>During an interview on 06/17/25 at 1:17 PM the Administrator was asked if she had a grievance related to R71's UA not being ordered and completed. The Administrator stated yes, it was investigated and confirmed that RN6 had not ordered the UA. The administrator was asked what her expectations were for staff following physician orders. The Administrator responded, I expect the staff to enter the physician orders and implement them.</p> <p>During an interview on 06/19/25 at 8:40 AM, the Nurse Practitioner (NP) was asked if she recalled the incident with the UA not being ordered. NP stated that she did not recall this incident but would have expected the staff to put the order in and to follow it.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and review of facility policies titled, Personal Hygiene, the facility failed to properly don (put on) a hair restraint while working in one of three kitchenettes (an area in which the food was served). This had the potential to increase the risk of foodborne illnesses that would affect 54 residents receiving an oral diet.</p> <p>Findings include:</p> <p>Review of a facility policy titled, Personal Hygiene dated 12/27/24 indicated .It is the intent of this center to establish guidelines for dining and nutritional services associates that promote personal hygiene and infection control prevention measures.A hairnet and/or beard restraint should be worn while in the food prep, production, and serving areas.</p> <p>An observation was conducted on 06/16/25 at 12:29 PM of the second-floor dining room. Kitchen Aide (KA)1 was observed serving the noon meal from the kitchenette. This observation continued until 1:06 PM when KA1 was interviewed. KA1 stated that she just forgot to don (put on) a hair net.</p> <p>During an interview on 06/17/25 at 12:54 PM, the Dietary Manager (DM) stated staff were to don a hair restraint whether that was a cap or hair net to keep the potential of hair follicles from contaminating the food served to the residents.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, review of the facility policy titled, Transmission-Based Precautions, and Centers for Disease Control (CDC) guidance, the facility failed to adhere to infection control practices and policies for one of two residents Resident (R) (R130). Specifically, the facility failed to ensure staff wore a gown for a resident on Enhanced Barrier Precautions while bathing and during wound care. The deficient practice increased the risk for cross contamination and infections.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Transmission-Based Precautions, dated 12/27/24, provided by the facility indicated, Enhanced Barrier Precautions are indicated for patients with any of the following: . wounds and indwelling medical devices even if the patient is not known to be infected or colonized with MDRO. Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact activities that provide opportunities for transfer of multi-drug resistant organisms (MDROs) to staff hands and clothing. MDROs may indirectly transfer from patient-to-patient during high contact activities. The use of gown and gloves for high-contact patient care activities is indicated, when Contact Precautions do not apply, for nursing home patients with wounds and/or indwelling medical devices regardless of MDRO colonization . Examples of high contact care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, and Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, and Wound care.</p> <p>During an observation of R130's wound care on 06/18/25 at 8:55 AM, Registered Nurse (RN8) entered R130's room to perform wound care. Certified Nursing Assistant (CNA) 11 was already in the room giving R130 a bed bath. CNA11 was not wearing a gown. RN8 sanitized hands, donned (put on) a gown and gloves and completed wound care. CNA11 assisted with positioning resident and was still not wearing a gown. R130 also had an indwelling feeding tube and foley catheter. An EBP sign was posted on R130's bedroom door. The EBP sign stated Providers and staff must also: wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting, and device/wound care.</p> <p>Review of R130's Face Sheet located under the Resident Summary tab of the electronic medical record (EMR) revealed R130 was admitted to the facility on [DATE] with diagnoses of gastrostomy, Alzheimer's disease, pressure ulcer of sacral region stage 4, retention of urine, and pressure ulcer of unspecified site stage 2.</p> <p>Review of the quarterly Minimum Data Set (MDS) located under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 04/15/25 showed documentation that staff assessed R130 had severe cognitive impairment. The MDS also documented that R130 had an indwelling urinary catheter and a feeding tube.</p> <p>Review of R130's Care Plan located under the Care Plan tab in the EMR revealed no documentation of Enhanced Barrier Precautions on the care plan.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Wynfield Park Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 223 W.Third Avenue Albany, GA 31701	

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R130's Resident's Consolidated Order under the Orders tab of the EMR revealed no order for Enhanced Barrier Precautions.</p> <p>During an interview on 06/18/25 at 9:38 AM, CNA11 stated, EBP includes wearing gown and gloves during bathing, catheter, and wound care. I didn't wear a gown and just didn't think about it. CNA11 verified the sign was on the door.</p> <p>During an interview on 06/19/25 at 2:06 PM, the Director of Nursing (DON) stated, The infection prevention nurse keeps up with tracking residents on EBP on a list and does frequent rounds to ensure all signs are on resident doors and residents are discussed during shift meetings. I would not expect to see EBP on the care plan and would not expect to see an order for EBP. I would expect staff to follow the EBP signs on the resident's door.</p>