STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115626	A. Building B. Wing	02/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hazelhurst Court Care and Rehabilitation Center	180 Burkett Ferry Road Hazlehurst, GA 31539

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41914 Based on Observations, staff interviews, and review of facility documents, the facility failed to maintain a clean and homelike environment for one of 24 rooms (Rm 33). Specifically, the facility failed to ensure Rm 33 privacy curtain was free of brown stains, and a white chalky substance on the curtain. Findings include: Observations on 1/31/2025 at 8:47 am, 2/1/2025 at 8:30 am, and 2/2/2024 at 8:42 am of privacy curtain for Rm 33 bed A revealed curtain had brown stain on the outer aspect of the curtain and a white chalky substance on the bottom hem of the curtain facing the door. Review of the facility document titled Complete Room Cleaning revealed under Purpose: The complete room cleaning schedule insures that each resident room is discharge-cleaned on a monthly basis. Under section labeled Patient Room (l) Cubicle Curtains- check and report any soil or damage to supervisor. Review of the deep clean schedule for December 2024 revealed room [ROOM NUMBER] was deep cleaned on 12/4/2024, in January 2025 room [ROOM NUMBER] was not on the schedule as being deep cleaned, and for February 2025 room [ROOM NUMBER] was not on the schedule to be cleaned. Conformation walking rounds conducted on 2/2/2025 at 8:45 am with the Administrator and housekeeping Account Manager confirmed observations of privacy curtain for Rm 33 during rounds. During an interview on 2/2/2025 at 9:00 am with the Account Manager revealed that each resident's room is deep cleaned monthly to include the vents, privacy curtains are removed and replaced if soiled, wiping down the walls, cleaning the windowsills, bed frames, sweeping and mopping the floors. Further interview also revealed that during the daily cleanings there are five steps that are followed that include checking the curtains for any stains so that they can be replaced if needed. During an interview on 2/2/2025 at 9:05 am with Housekeeper HH revealed that she cleaned room [ROOM NUMBER] this morning and did not notice that the curtains were soiled and needed to be changed. During the interview staff member also stated that when she cleans the resident's room, she starts by taking out the trash and then wipe down everything in the room cleaning the bathroom last. Staff member again confirmed that she did not check the privacy curtains when cleaning room [ROOM NUMBER]. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/2/2025 at 9:15 am with the Administrator, housekeeping follows a five and seven step process for cleaning the residents' rooms that included checking the curtains for any stains and to ensure that the curtains are in good repair. It was further revealed that he expected the housekeeping staff to follow those steps to ensure that the residents' environment is clean at all times.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675 Based on record reviews and interviews, and review of the facility's policy Transfer/Discharge Outside the Facility, the facility failed to provide a written reason for transfer to the resident or their representative for one of two residents reviewed for hospitalization , resident (R) 17. Findings include: Review of the facility policy titled Transfer/Discharge Outside the Facility , dated February 2015 revealed The resident/patient and/or family/responsible party will be notified of the transfer in writing, except when a transfer is due to an unplanned, acute clinical need. This type of transfer will be communicated verbally, with written documentation to follow in the medical record. R17 was admitted to the facility on [DATE] with diagnoses that include but are not limited to unspecified dementia, unspecified severity, without behavioral disturbance and type 2 diabetes mellitus with hyperglycemia. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed R17's Brief Interview for Mental Status (BIMS) score was unable to be determined. Review of medical records revealed R17 was transferred to the hospital from the facility, on 5/13/2024 and again on 12/18/2024. Further review revealed no evidence of the provision of a reason for transfer/discharge provided to R17's representative on either date. Phone interview on 2/1/2025 at 4:26 pm with the resident's representative revealed the facility failed to provide a written reason for transfer/discharge to the representative on 5/13/2024 and 12/18/2024. Interview on 2/2/2025 at 8:17 am with Licensed Practical Nurse (LPN) CC, revealed the facility does not provide anything in writing to the resident or representative as to reason for discharge/transfer. During an interview on 2/2/2025 at 8:41 am, LPN EE revealed that when a resident is discharged to the hospital, she completes a document in the electronic health record and prints that document to give to emergency medical services which includes a reason for transfer. She revealed the facility does not provide a written reason for transfer/discharge to the representative or the resident. During an interview on 2/2/2025 at 8:44 am with the Business Officer Manager (BOM), revealed the facility will call the family representative and notify them of the reason for transfer/discharge but does not provide anything in writing. An interview on 2/2/2025 at 8:51 am with the Director of Nursing (DON) revealed the facility will call family or representative to notify the reason for transfer/discharge. She verified nothing in writing is given to the representative because the facility knows the resident is returning to the facility.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675 Based on record reviews, interviews, and review of the facility's policy Bed Hold, the facility failed to provide a notice of bed hold for one of two residents (R)(R17) reviewed for hospitalization . Findings include: Facility policy titled Bed Hold, revised on 3/3/2020 revealed Policy: A copy of the bed hold agreement is also provided to the resident or responsible party prior to a resident's transfer to a hospital or start of a therapeutic leave. 2. In case of emergency transfer the resident or responsible party is provided with written notification within 24 hours of the transfer. R17 was admitted to the facility on [DATE] with diagnoses that include but are not limited to unspecified dementia, unspecified severity, without behavioral disturbance and type 2 diabetes mellitus with hyperglycemia. Review of medical records revealed R17 was transferred to the hospital from the facility, on 5/13/2024 and again on 12/18/2024. Further review revealed no evidence of the provision of a notice of bed hold provided to R17's representative on either date. An unsigned bed hold agreement was located in the resident's record for 12/18/2024. During a phone interview on 2/1/2025 at 4:26 pm with the resident's representative revealed the facility did not provide a written bed hold agreement to the representative on 5/13/2024 or 12/18/2024. Interview on 2/2/2025 at 8:41 am with Licensed Practical Nurse (LPN) EE revealed that when a resident is discharged to the hospital, she completes a document in the electronic health record and prints that document to give to emergency medical services which includes a bed hold agreement. She revealed the facility does not send or give a written bed hold agreement to the representative or the resident. During an interview on 2/2/2025 at 8:44 am with the Business Officer Manager (BOM), it was revealed the facility will call the family representative and notify them of the bed hold agreement but does not provide anything in writing. Interview on 2/2/2025 at 8:51 am with the Director of Nursing (DON) revealed the resident is given the bed hold agreement and facility will call family or the representative. She verified nothing in writing is given to the representative because the facility knows the resident is returning to the facility.

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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. 42463 Based on observations, record reviews, staff interviews, and review of the facility's policy titled, RAI/Care Planning Management, the facility failed to follow the care plan related to providing oxygen as ordered for three of 13 Residents (R) (R12, R7, and R14) reviewed for oxygen administration. The deficient practice had the potential to place the resident at risk for medical complications, unmet needs and a diminished quality of life. Findings include: Review of the facility's undated policy titled RAI/Care Planning Management under Interim Baseline Care Plan revealed, Under the section titled, The Care Plan revealed, .The Interim Baseline Care plan will be the guide for the comprehensive care plan Care plans are to be accessible for clinical staff in order to facilitate care plan interventions or to update as indicated due to resident condition change. 1. Record review of Electronic Medical Record (EMR) for R12 revealed diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), hypoxemia and shortness of breath. Review of Physician Orders dated 12/25/2024 for R12 revealed, orders for oxygen (O2) at 3 (three) liters (L) per nasal cannula (NC) for shortness of breath (SOB). Review of care plan with revision date of 11/18/2024 revealed, R12 has DX (diagnosis) COPD with interventions that included, but not limited to: Administer medications as ordered with date initiated, 12/12/2024 and O2 as ordered with date initiated, 8/4/2023. Observation on 1/31/2025 at 8:00 am revealed R12 receiving O2 therapy via (by way of) nasal cannula from the oxygen concentrator set at 7 (seven) L/min (minute). Observation on 2/1/2025 at 10:20 am revealed R12 receiving O2 therapy via nasal cannula from the oxygen concentrator set at 7 L/min. Observation and Interview on 2/1/2025 at 10:30 a.m. with Licensed Practical Nurse EE and the Director of Nursing (DON) revealed, R12 receiving O2 therapy via nasal cannula from the oxygen concentrator set at 7 L/min. LPN EE reviewed R12's physician orders to verify the correct oxygen setting and confirmed that oxygen was to be administered at 3L/min via NC. Interview on 2/1/2025 at 2:18 pm with Minimum Data Set (MDS) Coordinator revealed she was responsible for developing and entering care plans. She reviewed R12 physician orders and verified the oxygen rate was to be set at three liters per minute. She then reviewed the care plan and verified the care plan stated, oxygen as ordered. She confirmed that staff failed to follow the care plan. The MDS Coordinator revealed her expectations of staff were to follow the care plan clearly says, oxygen as ordered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/1/2025 at 2:28 pm DON confirmed the facility failed to follow the care plan for R12 related to oxygen. She revealed she expects her nurses to check the rates during med pass and to provide care per the physician orders and care plans. 49675 2. Review of the medical record for R7 revealed diagnoses that included but are not limited to COPD, unspecified. Review of Physician Orders dated 8/31/2023 revealed orders for oxygen at two liters per minute via nasal canula as needed. Review of care plan with revision date of 8/3/2024 revealed a diagnosis of COPD. Interventions included but not limited to: Administer medications as ordered with date initiated, 10/10/2022 and oxygen via nasal canula with date initiated 10/10/2022. Interview on 2/1/2025 at 2:20 pm with Minimum Data Set (MDS) Coordinator revealed she develops and enters care plans. She reviewed R7's physician orders and verified the oxygen rate was to be set at two liters per minute. Next, she reviewed and verified the care plan stated, administer medications as ordered. She confirmed that staff failed to follow the care plan. The MDS Coordinator revealed her expectations of staff were to follow the care plan. 3. Review of the medical record for R14 revealed diagnoses that included but are not limited to acute respiratory failure without hypoxia. Review of Physician Orders dated 5/1/2024 revealed orders for oxygen at four liters per minute via trach collar. Review of care plan with revision date of 6/1/2024 revealed a diagnosis of acute respiratory failure and respiratory disorder. Interventions included but not limited to: oxygen via trach collar as ordered, initiated on 6/29/2023. Interview on 2/1/2025 at 2:20 pm with the MDS Coordinator who reviewed R14's physician orders and verified the oxygen rate was to be set at four liters per minute. Next, she reviewed and verified the care plan stated, oxygen via trach collar as ordered. She confirmed that staff failed to follow the care plan. The MDS Coordinator revealed her expectations of staff were to follow the care plan. Interview on 2/1/2025 at 2:28 pm DON confirmed the facility failed to follow the care plan for R14 related to oxygen. She revealed she expects her nurses to check the rates during med pass and to provide care per the physician orders and care plans.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42463 Based on observations, record reviews, staff interviews, and review of the facility's policy titled, Respiratory System Management Standard, the facility failed to ensure that the physician's order for oxygen administration was followed for three of 13 Residents (R) (R12, R7, and R14) reviewed for oxygen administration. The deficient practice had the potential to place the resident at risk for medical complications, unmet needs and a diminished quality of life. Findings include: Review of the facility's undated policy titled Respiratory System Management Standard under the section titled Oxygen Therapy Protocol revealed, Procedures to follow in order: 1. Check the physician's orders in the resident's clinical record 10. set the oxygen flow rate as ordered. 1. Review of R12's Electronic Medical Record (EMR) revealed diagnoses that included but not limited to Chronic Obstructive Pulmonary Disease (COPD), hypoxemia and shortness of breath. Review of R12's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed, Sections C (Cognitive Patterns)- a Brief Interview of Mental Status (BIMS) of 14; Section J (Health Conditions)-Shortness of Breath (SOB) or trouble breathing when lying flat; Section O (Special Treatments, Procedures, and Programs)- received oxygen therapy while a resident. Review of R12's Physician Orders dated 12/25/2024 revealed orders for oxygen (O2) at 3 (three) liters (L) per nasal cannula (NC) for shortness of breath (SOB). Observation on 1/31/2025 at 8:00 am revealed R12 lying in bed receiving O2 therapy via (by way of) nasal cannula from the oxygen concentrator set at 7 (seven) L/min (minute). Observation on 2/1/2025 at 10:20 am revealed R12 lying in bed receiving O2 therapy via nasal cannula from the oxygen concentrator set at 7 L/min. Observation and Interview on 2/1/2025 at 10:30 am with Licensed Practical Nurse EE and the Director of Nursing (DON) revealed, R12 lying in bed receiving O2 therapy via nasal cannula from the oxygen concentrator set at 7 L/min. LPN EE revealed that she was responsible for making sure the oxygen setting was correct. She revealed that she usually checked the oxygen settings during medication pass however, she had not checked it. LPN EE confirmed the oxygen was set at 7L/min. LPN EE reviewed R12's physician orders to verify the correct oxygen setting and confirmed that oxygen was to be administered at 3L/min via NC. An interview on 2/1/2025 at 10:35 am with DON revealed, her expectations of staff that they ensure oxygen was administered as ordered. She stated they should be checking oxygen settings during their medication pass and as needed. 49675 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record for R7 revealed diagnoses that included but are not limited to COPD, unspecified. Review of 7's Quarterly MDS assessment dated [DATE] revealed, Sections C (Cognitive Patterns)- a Brief Interview of Mental Status (BIMS) of 9; Section J (Health Conditions)-Shortness of Breath (SOB) with exertion or trouble breathing when lying flat; Section O (Special Treatments, Procedures, and Programs)- received oxygen therapy. Review of Physician Orders dated 8/31/2023 revealed orders for oxygen at two liters per minute via nasal canula as needed. Observation on 1/31/2025 at 9:30 am revealed R7 lying in bed receiving oxygen therapy via nasal canula at three liters per minute. Observation on 2/1/2025 at 8:36 am revealed R7 lying in bed receiving oxygen via nasal cannula at three liters per minute. Observation and rounding on 2/1/2025 at 10:30 am with LPN BB revealed R7 lying in bed receiving oxygen via nasal cannula at three liters per minute. LPN BB revealed that she was responsible for making sure the oxygen setting was set on the prescribed rate during morning medication pass. She admitted she did not check the rate and confirmed the oxygen was set on three, not the prescribed rate. LPN BB reviewed R7's physician orders and verified the rate should be set at two liter per minute. Interview on 2/1/2025 at 10:35 am with the DON revealed her expectations are that staff ensure oxygen is administered as ordered. She stated nurses should be checking oxygen settings during their medication pass since oxygen is a medication. 3. Review of the medical record for R14 revealed diagnoses that included but are not limited to acute respiratory failure without hypoxia. Review of 14's Quarterly MDS assessment dated [DATE] revealed, Sections C (Cognitive Patterns)- BIMS of 99, unable to determine Section O (Special Treatments, Procedures, and Programs)- received oxygen therapy. Review of Physician Orders dated 5/1/2024 revealed orders for oxygen at four liters per minute via trach collar. Observation on 1/31/2025 at 8:50 am revealed R14 lying in bed receiving oxygen therapy via trach collar at five liters per minute. Observation on 2/1/2025 at 8:40 am revealed R14 lying in bed receiving oxygen via trach collar at five liters per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and rounding on 2/1/2025 at 10:30 am with LPN BB and the DON revealed R14 lying in bed receiving oxygen via nasal cannula at five liters per minute. LPN BB revealed that she was responsible for making sure the oxygen setting was set on the prescribed rate during morning medication pass. She admitted she did not check the rate and confirmed the oxygen was set on five, not the prescribed rate. LPN BB reviewed R14's physician order and verified the rate should be set at four liters per minute. Interview on 2/1/2025 at 10:35 am with the DON revealed her expectations are that staff ensure oxygen is administered as ordered. She stated nurses should be checking oxygen settings during their medication pass since oxygen is a medication.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 49675 Based on observation, record review, resident and staff interviews, and the facility policy, MENUS, the facility failed to ensure they offered an appealing option of similar nutritive value to residents for lunch and dinner meals and failed to provide preferences for meals for one resident (R) 30. This deficient practice had the potential to affect 50 of 53 residents receiving an oral diet. Findings include: The facility tile, MENUS not dated, revealed, well planned menus aide in meeting the nutritional and psychosocial needs of the residents and are developed, taking into consideration certain budgetary allowances, available personnel, and equipment. When changes in the menus are needed, the changes must provide equal nutritive value. A Resident Council meeting was held on 2/2/2025 during the survey. Residents, specifically R40, revealed that the facility does not have an alternate menu and that if they do not like what is being served their only option is to ask for a sandwich or soup. Other residents expressed concerns regarding lack of choices for food being served. Reveal of the facility's fall/winter 2024 menu revealed no alternate meal choice on the menu for lunch or dinner. Interview on 2/1/2025 at 10:34 am with the Dietary Manager (DM) revealed that the vendor provides menus to the facility and they are without an alternate meal choice. She revealed residents are offered a sandwich, soup, or both as an alternate. Interview on 2/1/2025 at 12:40 pm with Dietary Aid (DA) FF revealed there is no alternate menu for residents. She revealed she offers residents that do not like what is on the menu a sandwich or soup. Interview on 2/1/2025 at 12:45 pm with DA GG revealed there is no alternate choice on the menu for residents. She revealed if a resident did not like what was being offered she would offer them sandwich or soup. Interview on 2/1/2025 with the Registered Dietician (RD) at 12:53 pm revealed that she reviews and signs off on menus that are issued by Sysco. She confirmed there are no alternate choices on the menus that provide two hot entrees but residents can request a sandwich with protein or soup. She revealed she has never been provided an alternate meal menu. She believed due to budget reasons, no one from the facility has ever requested alternative menus from Sysco. Interview on 2/2/2025 at 9:08 am with the administrator revealed he was aware that residents do not have an alternate menu but states a sandwich and soup are always available. 41165 (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the initial screening on 1/31/2025 at 8:55 am, R30 stated that if she does not like the meal that is served, she is not offered, and she does not get an alternate meal. Observations made on 1/31/2025 through 2/2/2025 revealed there were no alternate meals listed on the menu, and there was not an alternate meal on the hot steam tray unit during meal service. 1/31/2025 at 12:03 pm, R30 stated that she has been at the facility for one year. She stated that she never has a choice of meals. R30 stated again that if she does not like what is served, she is not offered, and she does not get an alternate meal. Interview with the Registered Dietician (RD) on 2/1/2025 at 12:53 pm revealed that she was aware that there is not an alternate meal listed on the menu. She stated that residents can have a sandwich or soup, but she was not sure what the sandwich choice was. RD stated that she was not in charge of the budget. She stated that she has never been provided an alternate meal menu. Interview with DON on 2/2/2025 at 8:48 am revealed that she knows that residents are offered a peanut butter and jelly sandwich, she stated that if they're having a meal and they don't want it they offer them sandwiches. Interview with the Administrator on 2/2/2025 at 9:30 am, he stated that he was aware that residents are not offered a hot alternate meal. He stated that they are offered a sandwich or soup. The Administrator stated that residents could get a grilled cheese sandwich.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675 Based on observations, staff interviews, and review of the facility policies titled, Food Storage the facility failed to discard food from the stand-up cooler by the expiration date. This deficient practice had the potential to affect 50 of 53 residents receiving an oral diet. Findings include: Review of the facility policy titled Food Storage, revealed under Procedure: 15. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 48 hours or discarded. The tour of the kitchen on [DATE] started at 8:23 am with the Dietary Manager (DM). The following concerns were identified during the tour in the stand-up cooler: 1. A resealable plastic bag that contained sliced ham with an expiration date [DATE]. 2. A plastic container of chicken and noodles with an expiration date of [DATE]. Interview on [DATE] at 8:35 am with the DM who confirmed the expired ham and chicken and noodles and discarded them. She stated her expectation was that staff throw away items before they are expired. The risks would be illness to the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115626	A. Building B. Wing	02/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hazelhurst Court Care and Rehabilitation Center	180 Burkett Ferry Road Hazlehurst, GA 31539

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 - Many	Provide and implement an infection prevention and control program. 41165 Based on observations, staff interviews, record review, and review of the facility policy titled, Tracheostomy Care, the facility failed to wash/sanitize hands and change gloves during tracheostomy care for one of one resident (R) (14) reviewed for tracheostomy care, and the facility failed to properly dispose of soiled items. This failure increased R14's risk for infection. Findings include: Review of the facility policy titled, Respiratory System Management Standard, dated August 2021, revealed: Tracheostomy care procedure Nursing actions. 3. [NAME] clean gloves and remove the used tracheostomy dressing being careful to keep the tracheostomy tube in place. 4. Remove used gloves and discard per facility standard. 5. perform hand hygiene. Review of the undated Admission Record for R14 located in the Electronic Medical Record (EMR), revealed R14 was admitted to the facility with multiple diagnoses including but not limited to tracheostomy status, acute respiratory failure with hypoxia, respiratory disorder, unspecified, dependence on supplemental oxygen, and cerebral palsy. Review of R14's care plan revealed R14 had a tracheostomy related to diagnosis of acute respiratory failure, respiratory disorder, cerebral palsy, intellectual disabilities, dependence on supplemental O2, and persistent vegetive state. Observations made on 2/1/2025 at 10:00 a.m. revealed R14 lying in bed with head of the bed elevated. R14 was non-verbal. Tracheostomy was in place and secured with ties. Oxygen (O2) via trach collar at 5 liters (L)/minute. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Trach care observation on 2/1/2025 at 11:10 am provided by wound care nurse Registered Nurse (RN) AA and assisted by Licensed Practical Nurse (LPN) CC revealed both RN AA and LPN CC washed hands with soap and water, and donned Personal Protective Equipment (PPE) before providing trach care. LPN CC washed her hands with soap and water during the procedure after donning and doffing gloves. RN AA did not wash her hands after donning and doffing gloves. Observation revealed RN AA washed her hands with soap and water before donning gloves before procedure. RN AA placed a pulse oximeter on R14 right fourth digit finger. RN AA removed her gloves, donned gloves and placed a chux pad on the bedside table. RN AA opened the package with the trach collar, opened the inner cannula package, and opened the trach care kit. LPN CC removed inner cannula and 4x4 dressing from R14 trach and placed it in the trash. LPN CC removed her gloves, washed her hands with soap and water, and donned gloves. LPN CC opened a bottle of saline and poured it into trach kit . RN AA removed gloves and donned gloves from the trach care kit. RN AA removed drape from the kit and placed the drape over R14 chest area. RN AA and LPN CC removed the trach collar and threw it in. LPN CC removed her gloves, washed her hands with soap and water and donned gloves. RN AA dipped a Q-tip in saline and swabbed under the right side of the trach collar attached to R14. RN AA wet a 4x4 gauze in the saline and wiped the left side of the trach collar and wiped under the bottom of the trach collar. RN AA cleaned around the trach stoma with a wet 4x4 gauze. RN AA placed 4x4 dressing under trach stoma. RN AA threw chux pad in trash, removed PPE and washed her hands with soap and water. RN AA and LPN CC placed a new trach collar under R14 trach stoma. LPN CC removed PPE and washed her hands with soap and water. RN AA placed soiled towels in a yellow plastic trash bag and placed the bag on the floor next to the plastic container that contained trach supplies. The container of trach supplies was on the floor between a red trash can and the yellow plastic trash bag containing the soiled towels. The yellow plastic trash bag remained on the floor for two hours after trach care was provided. Interview with LPN CC on 2/1/2025 at 11:05 am revealed she does not provide trach care. LPN CC stated that she assists the treatment nurse with trach care. She stated that she has been working at the facility for two years and she has not received an in-service on trach care. Interview with wound care nurse RN AA on 2/1/2025 at 11:30 am revealed RN AA acknowledged that she did not wash her hands before donning and doffing gloves throughout trach care procedure. RN AA stated that she should have washed her hands every time she took her gloves off, but she did not want to leave the resident. RN AA stated that she received a trach care in-service about two years ago. An interview with the Director of Nursing (DON) on 2/1/2025 at 12:35 pm, who stated that her expectations is for the treatment nurse to wash her hands before the procedure (trach care), and to change gloves before, during, and after the procedure. An interview with LPN BB on 2/1/2025 at 1:30 pm revealed LPN BB removed the yellow trash bag from floor in room R14. LPN BB stated that the trash bag should not have been on the floor.