STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145514	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Effingham Healthcare & Senior Living	1610 North Lakewood Drive Effingham, IL 62401

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was available 7 days a week for 8 consecutive hours a day and failed to ensure a full time Director of Nursing (DON) was on staff. This failure has the potential to affect all 36 residents in the facility. The Findings Include:1. On 04/26/2026 at 10:40 AM, V1 (Administrator) stated the facility has not had a Director of Nursing (DON) since 3/13/26. V1 stated they are in the process of hiring a new one, but a start date has not yet been set. V1 stated in the interim, the facility staff have been doing the scheduling and if an issue arises, they contact a regional nurse with any questions or concerns. 2. On 4/26/2026 at 10:45 AM, V1 stated every other weekend, the facility does not have a Registered Nurse (RN) available to work the full 8-hour shift. V1 stated they are seeking to hire an RN who is able to work a full 8-hour shift on the weekends that lack coverage. The facility's working schedules for February 2026, March 2026 and April 2026 documented the following dates were lacking RN hours: 2/3/26, 2/4/26, 2/7/26, 2/8/26, 2/13/26, 2/17/26, 2/18/26, 2/21/26, 2/22/26, 2/26/26,3/2/26, 3/3/26, 3/8/26, 3/21/26, 3/22/26, 4/4/26, 4/5/26, 4/8/26, 4/14/26, 4/18/26, 4/19/26, 4/22/26 and 4/20/26.The Director of Nursing Services policy and procedure states that the nursing services department is under the direct supervision of a registered nurse .2. the director is employed full time and is responsible for, but is not necessarily limited to .h. ensuring sufficient and competent staffing levels to meet the needs of residents as indicated by the facility assessment and resident care plans; j. participating in the planning and budgeting of nursing services .The Long-Term Care Facility Application For Medicare and Medicaid application dated 4/26/26, documents that 36 residents reside in the facility.

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

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

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F 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. Based on observation, interview, and record review, the facility failed to provide alternative substitutes of similar nutritive value at mealtimes. This has the potential to affect all 36 residents residing in the facility. The Findings Include: On 4/26/26 at 12:00 PM, the meal served was observed to be roasted turkey, glazed carrots and stuffing. On this date and time, V15 (Cook) stated there was not a planned meal alternative for the residents. V15 stated that they have a planned menu signed off by the Dietitian. V15 said that if a resident does not like what is served, they will make them a cold cut sandwich, an egg salad sandwich or peanut butter and jelly after they are finished with all meals being served out. During the lunch meal at 12:45 PM, R21 stated that she does not like the stuffing, and carrots are not her favorite. R21 stated she does not know if they have other items available to ask for. On 4/27/26 at 10:00 AM during Resident Council meeting, R5, R9, R21 and R29 all stated that they do not have a variety of foods to choose from for meals and would like to have an alternative option to choose from. R9 further stated they do not always post the menu up on the board and that is the only way they know what is being served at the next meal. R9 stated it would be nice to know ahead of time what they are eating and what the alternative would be to choose from. On 4/28/26 at 1:00 PM, V1 (Administrator) stated that they are working to incorporate an always available menu that would include a variety of protein and side options to choose if residents do not like the main selections. V1 confirmed at this time there are no planned meal alternatives, it is just what they have from leftovers from previous meals or the options that V15 mentioned above. V1 stated there is not a policy regarding alternative food selections. The Long-Term Care Facility Application For Medicare and Medicaid dated 4/26/26, documents 36 residents currently reside in the facility.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the privacy of 2 (R1 and R7) of 4 residents reviewed for resident rights in the sample of 27.Findings Include:1. R1's admission Record documented R1 was admitted to the facility on [DATE] with a diagnosis of pressure ulcer of sacral region. R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 11, indicating R1 has moderate cognitive impairment. R1's current Care Plan documents a Focus area of Skin Integrity: Resident may be predisposed to develop skin impairment caused by pressure. R/T (related to) Moderate Risk per Braden Scale- Risk factors . This Focus area includes interventions of Braden/Skin risk assessment quarterly, pressure relieving devices, and apply incontinent barrier cream. On 4/29/26 at 11:00 AM, V3 (Registered Nurse/RN), V2 (Wound Nurse), and V4 (Certified Nursing Assistant/CNA) provided wound care to R1 with this surveyor present. R1 was in bed with blankets pulled back, incontinence brief loosened, and lower body exposed when this surveyor entered room. R1's roommate was in their bed and appeared to be sleeping. V2, V3, and V4 removed R1's incontinence brief and administered treatment to the pressure ulcer located on R1's left hip. The privacy curtain was not pulled throughout the observation. During administration of the treatment, V2 and V3 left the room to obtain more supplies. The door to the hallway was left open as R1 was exposed. 2. R7's admission Record documented an admission date of 9/5/25 and included diagnoses of pressure ulcer of sacrum and osteomyelitis. R7's MDS assessment dated [DATE] documents a BIMS score of 09, indicating a moderate cognitive deficit. R7's current Care Plan documents a Focus area of Skin Integrity: Resident has actual impairment to skin integrity of the sacrum r/t (related to) Surgical, Non-healing wound .Date Initiated: 09/05/2025. This Focus area includes interventions of administer treatment as ordered. On 4/29/26 at 11:19 AM, V2 (Wound Nurse), V3 (RN), and V4 (CNA) administered treatment to the pressure ulcer located on R7's sacrum with this surveyor present. There were two roommates present in R7's room with the privacy curtains pulled around their beds. The door to R7's room was left open throughout parts of R7's treatment when V3 exited the room to obtain supplies. However, R7's bed was located behind the door, so she wasn't exposed to the hallway. During the treatment, V17 (CNA) entered R7's room without knocking. V17 entered the pulled curtain around one of R7's roommates, assisted her to a wheelchair, and wheeled the roommate out of the room while R7's buttocks were exposed for the roommate to see. V17 then entered the room a second time without knocking. V17 entered the other roommates closed privacy curtain and assisted her up and out of the room. V17 took the roommate past R7, whose buttocks were exposed. Throughout this observation, R7's buttocks were exposed and V2, V3, and V4 were administering the treatment to the pressure ulcer located on R7's sacrum. On 4/29/26 at 1:59 PM, V1 (Administrator) stated she would expect privacy curtains to be pulled and doors to be closed during treatments to protect the privacy of the resident. On 4/29/26 at 2:27 PM, V2 (Wound Nurse) stated she would expect staff to knock before entering the room and wait until treatments were completed to provide non-emergent care to other residents in the room. V2 stated she would expect doors to be closed, and privacy curtains pulled to protect the privacy of the residents. The facility Dignity Policy dated February 2021 documents, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.7. Staff are expected to knock and request permission before entering residents' rooms.11. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report allegations of a missing item to the state agency (Illinois Department of Public Health) for 1 (R27) of 2 residents reviewed for abuse in the sample of 27. Findings included:R27's Care Plan Summary/ Participation Record dated 4/9/2026 documented a care plan meeting with V2 (Wound Nurse), V5 (Minimum Data Set/MDS Coordinator), V10 (Social Services Director/SSD) and V13 (Family) with topic of discussion of missing shoes. On 04/27/2026 at 9:33 AM, V13 (Family) stated she had come into the facility a few weeks ago and noticed R27 was missing a pair of her Skechers shoes. V13 stated she alerted staff of the missing shoes and then had a care plan meeting with the facility on 4/9/2026 to discuss the missing shoes. V13 stated she is still waiting to hear from the facility on how they are planning to resolve the missing shoes. On 4/28/2026 at 11:06 AM, V4 (Certified Nursing Assistant/CNA) stated R27 was moved to a different room not too long ago. V4 stated she had been made aware that R27 was missing 2 different pairs of shoes, and the facility found one pair but not the other. On 4/28/2026 at 11:13 AM, V10 (SSD) stated about a few weeks ago, R27 was moved from one room to another room and V13 (Family) notified V10 that R27 was missing 2 pair of shoes. V10 stated the facility found one pair of R27's shoes but not the other pair. V10 stated she did not file a grievance form or list it on the grievance log. V10 stated she had a care plan meeting with V13 where they discussed missing shoes on 4/9/2026. V10 stated she notified V9 (Housekeeping Supervisor) of the missing shoes so they could look for them but is not aware if V9 has done that yet or not. On 4/28/2026 at 11:21 AM, V1 (Administrator) stated she was made aware a few weeks ago that V13 notified the facility of R27 missing a pair of shoes. V1 stated V9 is in the process of looking for the shoes but she is not sure where she is in that process. V1 stated she does not have a grievance on file for the missing shoes and did not report it to the state department as abuse-theft. The facility policy Abuse, Neglect, Exploitation or Misappropriation, - Reporting and Investigating (revision date September 2022) documented under Policy Statement: All reports of resident abuse (including injuries of unknown origin), neglect exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Under Policy Interpretation and Implementation 2. The administrator or the individual making the allegation immediately reports his or her suspicion on the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure PASRR (Preadmission Screening and Resident Review) Level 2 screenings were completed for 1 (R4) of 5 residents reviewed for screenings in the sample of 27.Findings Include:R4's Transfer/Discharge Report dated 4/29/26 documented R4 was admitted to the facility on [DATE]. This same report includes diagnoses of bipolar disorder, cerebral infarction, dementia, brief psychosis episode, and major depressive disorder.R4's Minimum Data Set (MDS) assessment dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 09, indicating R4 had moderate cognitive impairment.R4's current Care Plan documents a Focus area of, Anti-Psychotic: The resident uses anti-psychotic medications for brief psychotic disorder, paranoid delusions r/t (related to) MDD (major depressive disorder). Date Initiated: 09/25/2025. This Focus area includes the interventions to administer medications as ordered, consult with pharmacy as needed, and discuss with physician and family related to ongoing need for medications.R4's Notice of PASRR Level 1 Screen Outcome dated 8/8/22 documents No Level 2 required due to no serious mental illness.R4's Progress Note dated 7/8/25 documented, In house psychiatrist in to see resident on 7/3/25. New orders to start Quetiapine 25 mg (milligrams) PO (by mouth) q (every) HS (bedtime) and new diagnosis of brief psychotic disorder.R4's medical record did not document a new screening after the diagnosis of psychotic disorder on 7/8/25.On 4/28/26 at 9:45 AM, V1 (Administrator) stated they did not get a Level 2 screening after the new diagnosis of psychotic disorder on 7/8/2025.The admission Criteria policy dated 3/2019 documents, Our facility admits only residents whose medical and nursing care needs can be met .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure showers were provided as scheduled for 1 (R28) of 1 resident reviewed for ADLs (Activities of Daily Living) in the sample of 27.Findings Include:R28's admission Record documented an admission date of 10/31/25 and included diagnoses of complete lesion at C5 level and pressure ulcer of sacral region. R28's Minimum Data Set (MDS) assessment dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 15, indicating R28 is cognitively intact. This same MDS documents R28 requires substantial/maximal assist with bathing. R28's current Care Plan includes a Focus area with a start date of 11/10/25 of, ADL: Resident is usually able to perform ADLs with setup to mod (moderate) assist r/t (related to) complete lesion at c5 level spinal cord, depression, orthostatic HTN (hypertension), and S3PU (Stage 3 Pressure Ulcer) to buttock. This Focus area includes an intervention of Shower/bathe self: max (maximum) assist x (times) 1. Date Initiated: 11/10/2025. On 4/26/26 at 10:50 AM, R28 stated he didn't get a shower for a long time because he requested a day shift shower, and it took them a long time to make the change. R28 stated he just started getting showers about three weeks ago. The facility Shower List documents R28 should receive assistance with bathing on Monday, Wednesday, Friday, and Saturday. R28's document titled GG ADL Documentation documents NA (indicating bathing was not completed) on the following dates 3/4, 3/6, 3/7, 3/9, 3/11, 3/20, 3/21, 3/23, 3/27, 3/28, 4/1, 4/3, 4/4, 4/6, and 4/8. This same report does not document any initials, indicating R28 did not receive assistance with bathing on 3/5, 3/8, 3/10, 3/19, 3/22, 3/24, 3/26, 3/29, 3/30, 3/31, 4/2, 4/5, and 4/9. This indicates R28 did not receive assistance with bathing from 3/4-3/11 (9 days), 3/19-3/24 (6 days), and from 3/26-4/9 (15 days). On 4/28/26 at 3:23 PM, V16 (Certified Nursing Assistant) stated she has not been employed here very long but has previously come in on her days off to assist R28 with showers. V16 stated R28's showers used to be on night shift. This surveyor reviewed R28's shower sheets with V16 and asked when she may have assisted R28 with showers and V16 was unable to recall the dates she may have assisted him. On 4/29/26 at 2:42 PM, V2 (Wound Nurse) stated she didn't see any documentation of R28 refusing assistance with bathing and didn't have a good answer for why R28 did not receive assistance with bathing as scheduled. On 4/29/26 at 3:00 PM, V1 (Administrator) stated she would expect residents to be assisted with bathing as scheduled. The facility Bath, Shower/Tub policy dated February 2018 documents, Purpose: /the purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.Documentation: 1. The date and time the shower/tub bath was performed.5. If the resident refused the shower/tub bath, the reason(s).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure care plan fall interventions were implemented for 1 (R16) of 3 residents reviewed for falls in the sample of 27. Findings included:R16's admission Record documented an admission date of 10/07/2022 and included diagnoses of Alzheimer's disease, unspecified, transient cerebral ischemic attack, unspecified, major depressive disorder, recurrent, moderate, vitamin D deficiency, unspecified and anemia. R16's Minimum Data Set (MDS) assessment dated [DATE] documents a Brief Interview for Mental Status score of 10, indicating moderate cognitive impairment. Under Functional Abilities and Goals, the MDS documents that R16 needed partial/moderate assistance (helper does less than half the effort-helper lifts or holds trunk or limbs and provides less than half the effort) for toilet transfer and documented R16 used a wheelchair. R16's Care Plan documented a focus area of Fall Risk: resident is at risk for falls related to does not ambulate at this time due to wound to the left heel. Corresponding interventions listed anti-slip strips placed on floor next to resident's bed dated 10/20/2025, anti-slip strips in front of resident's bathroom toilet dated 3/4/2026 and call don't fall sign placed in room. On 04/29/2026 at 11:38 AM, R16's room did not have non-skid strips located in front of his bed, the bathroom had no anti-slip strips in front of the toilet and there was no call don't fall sign hanging in the room. On 04/29/2026 at11:40 AM, V6 (Certified Nursing Assistant/CNA) stated all fall interventions are communicated through a communication book. V6 stated R16's fall interventions do not include non-skid strips in front of his bed, bathroom or call don't fall sign. On 04/29/2026 at 11:42 AM, V3 (Registered Nurse/RN) stated all fall interventions are located on the residents care plan. V3 stated R16's Care Plan documented fall interventions that included non-skid strips to be in place in front of his bed, toilet and call don't fall sign hanging in his room, and they should be in place. The facility's communication binder called Care Needs Notices had no documentation of R16's fall interventions of non-skid strips in front of his bed, bathroom or a call don't fall sign. On 04/29/2026 at 11:54 AM, V5 (MDS Coordinator) stated she does enter all interventions on resident care plans. V5 stated once they complete the fall investigation and review the root cause, the facility will implement appropriate interventions. V5 stated V2 (Wound Nurse) will put out communication to staff on new interventions in place. V5 stated R16's Care Plan documented fall interventions that included non-skid strips in front of his bed, toilet, and a call don't fall sign and should be in place. On 04/29/2026 at 12:00 PM, V2 (Wound Nurse) stated after the fall investigation is completed with root cause, the IDT (interdisciplinary team) will meet and implement new and appropriate interventions. V2 stated V5 will document new interventions on the resident's care plan, and V2 will document in the Care Needs Notices book for the CNA staff. V2 stated the nursing staff are to check the care plans daily for any updated information and should have implemented R16's fall interventions of non-skid strips in front of his bed, toilet, and call don't fall sign. On 04/29/2026 at 12:15 PM, V1 (Administrator) stated, it is her expectation that staff implement and follow fall risk interventions in place for residents. The facility's Fall-Clinical Protocol (revision date March 2018) documented under Monitoring and Follow-Up.2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling.3. If interventions have been successful in fall prevention, the staff will continue approaches and will discuss periodically with the physician whether these measures are still needed.

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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 observation, interview, and record review, the facility failed to ensure standard infection control practices were implemented during medication administration and resident care for 2 (R7 and R35) of 13 residents in the sample of 27. Findings included:1. R7's admission Record documented an admission date of 9/5/2025 and included diagnosis of chronic kidney disease, stage 3, unspecified, acute kidney failure, unspecified, sepsis, pressure ulcer of sacral region, unstageable, and weakness. R7's Minimum Data Set (MDS) dated [DATE] documented a BIMS (Brief Interview for Mental Status) score of 9, indicating moderate cognitive impairment. This MDS also documented under Special Treatment/Programs that R7 had been receiving intravenous medications. R7's Medication Administration Record (MAR) documented DAPTOmycin-Sodium Chloride Intravenous Solution 500-0.9 MG (milligrams)/50ML (milliliters)-% (Daptomycin Sodium Chloride) Use 500 mg intravenously one time a day for osteomyelitis for 4 Weeks with a -Start Date of 03/31/2026. On 04/27/2026 at 10:47 AM, V8 (Registered Nurse/RN) donned a gown, completed hand hygiene then donned gloves. V8 entered R7's room and placed IV (Intravenous) supplies on R7's bedside table without wiping the table down and with no barrier placed. V8 hung the IV medication on the IV pole, opened the tubing and spiked the bag. V8 then primed the tubing with the medication. The IV tubing blue cap was touching the floor during priming of the tube. Once tubing was finished priming, V8 placed the tubing on the IV pole while touching the blue cap that had been on the floor. V8 then grabbed a saline flush with an alcohol wipe from the bedside table, opening both items and turning to R7. V8 returned the saline flush and alcohol wipe to the bedside table so she could push R7's right shirt sleeve up enough to access her IV site. Using both hands with the same gloves she had donned prior to entering R7's room and spiking/priming the medication and tubing, V8 then struggled to get the IV tale port to come down out of R7's shirt sleeve. V8's gloved hands touched R7's arm, bed and shirt. V8 got the IV access positioned where she could access it, grabbed an new alcohol pad, cleaned the IV access site and then flushed the site with the saline flush that had been sitting on the bedside table with no barrier. V8 flushed the site then connected the IV tubing to the IV access without cleaning the IV access point where the cap had been, with alcohol. Upon initiation of the IV medication, an alarm sounded for air. V8 then stopped the IV pump, removed the tubing port from the access, pulled the tubing from the pump and started flicking the tubing to remove air with the same gloved fingers. During this time, V8 was holding the IV connection site with her hand without donning or duffing of gloves or completing hand hygiene. V8 finished getting the air out of the IV tubing and placed it back in the IV pump. V8 reached into her scrub pants pocket to pull out keys for her medication cart, pulled the IV pump with her while the IV connector port was still in her left hand, used her right hand to unlock the medication cart and grabbed an alcohol pad. V8 returned to R7, cleaned her IV access site with an alcohol pad, and reconnected the tubing. During this observation, V8 never performed hand hygiene or changed gloves. The facility's Administration Set/Tubing Changes (revision date October 2024) documented under Purpose: The purpose of this procedure is to provide guidelines for aseptic administration set changes in order to prevent infections associated with contaminated IV (intravenous) therapy equipment. Preparation:.2. Assemble equipment and supplies as needed. Assess equipment for sterile condition. Do not use if not sterile. General Guidelines:1. Adhere to Standard-ANTT (Aseptic Non-Touch Technique) when connecting, changing and accessing administration set injection ports. Steps in the Procedure: 1. Perform hand antisepsis. 4. Prime new administration set, including add-on devices and tubing: .b. Remove cap from tubing, open roller clamp to prime tubing, then hold the distal end of tubing over sink or trash can (keep tip sterile) and allow all of the air bubbles to leave tubing;.6. [NAME] clean non-sterile gloves. 7. Connecting new tubing:. 2. R35's admission Record documented an admission date of 5/22/2024 and included diagnosis of osteoarthritis of knee, unspecified, type 2 diabetes mellitus with unspecified complications, urinary tract infection (UTI), site not specified and (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	muscle weakness (generalized). R35's MDS dated [DATE] documented a BIMS score of 12, indicating moderate cognitive impairment. R35's Care Plan documented a focus area of contact isolation related to urinary tract infection (start date of 4/18/2026) and resident has a urinary tract infection. Corresponding interventions included to educate resident and family on the need of isolation precaution. Educate family and staff regarding the transmission, pathophysiology, etiology and treatment of infection and give antibiotic therapy as ordered. R35's Physician Order Summary documented a discontinued date of 4/27/2026 of Zosyn Intravenous Solution 4-0.5 GM/100ML (Piperacillin Sodium-Tazobactam Sodium in Dextrose) Use 4.5 gram intravenously every 8 hours for UTI for 7 Days. On 04/26/2026 at 11:11 AM, V11 (Licensed Practical Nurse/LPN) entered R35's room with a saline flush. V11 did not don gown or gloves and did not complete hand hygiene prior to disconnecting the intravenous (IV) tubing and flushing R35's IV port. On 4/26/2026 at 11:12 AM, a contact isolation sign was observed on the outside of R35's door with personal protective equipment (PPE) available. On 04/26/2026 at 11:19 AM, V11 (LPN) stated she should have donned a gown and gloves when disconnecting R35's antibiotic from his intravenous connection and flushing his port. On 04/27/2026 at 11:26 AM, R35 was self-propelling in his wheelchair down the hallway. V7 (LPN) called out to R35 and told him she needed to see him real quick. R35's midline IV catheter tip was hanging out of his left forearm with dried blood on it with a dressing over the access port. R35 was alert and oriented. R35 stated his midline catheter came out this morning before 8:00 AM medication time and is not sure how it happened. On 4/27/2026 at 11:28 AM, V7 (LPN) walked up to R35 and removed his dressing and midline catheter in the hallway without donning a gown or gloves. V7 stated she had gone into R35's room around 8:00 AM this morning and noticed his midline catheter was out and notified V8 (Registered Nurse/RN). R35's Progress Note dated 4/27/2026 at 11:37 AM by V7 (LPN) documented R35's mid-line located in the left arm was noted to be out this am, this nurse removed all excess remaining which was taped to the arm. On 04/27/2026 at 12:10 PM V8 (RN) stated she was made aware that R35's midline catheter had come out around 8:00 AM this morning. V8 stated V7 should have immediately removed the catheter and dressing and used standard infection control practices for removal. On 04/27/2026 at 12:17 PM, V7 (LPN) stated she had not gotten back down to R35's room to remove his midline catheter or dressing this morning but she was busy. V7 stated she should have used a glove when removing the catheter and dressing but thought she might as well get it done when she saw R35 in the hallway. On 4/27/2026 at 1:00 PM V1 (Administrator) stated her expectations are that staff maintain standard infection control practices and follow facility policy and procedures. The facility's Standard Precautions (revision date September 2022) documented under Policy Statement: Standard precautions are used in the care of all residents regardless of their diagnoses or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infection agents. Standard Precautions include the following practice:.2. Gloves: a. Gloves (clean, non-sterile) are worn when in direct contact with blood, body fluids, mucous membranes, non-intact skin, and other potentially infected material. b. Gloves are worn when in direct contact with a resident who is infected or colonized with organisms that are transmitted by direct contact. (For specific pathogens, refer to current CDC isolation precautions guidelines.)