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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145606 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/28/2025 |
| NAME OF PROVIDER OR SUPPLIER Covenant Living - Windsor Park | | STREET ADDRESS, CITY, STATE, ZIP CODE 110 Windsor Park Drive Carol Stream, IL 60188 | |

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) |
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| <p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45906</p> <p>Based on observation, interview, and record review, the facility failed to follow physician orders to ensure residents with gastrostomy feeding tubes (GT) recieved cares to prevent complications.</p> <p>This applies to 3 residents (R42, R43, and R4) reviewed for G-tube management in a sample of 19.</p> <p>The findings include:</p> <p>1. On February 25, 2025 at 11:52 AM, R42 was noted with cough and talking with a gargly voice as though excessive moisture was present in his throat. On 2/26/25 at 9:26 AM, after wound care was completed by V13 (Wound Care Nurse) and V14 (CNA/Certified Nurse Assistant), V14 raised the head of R42's bed to 20 degrees. At 9:50 AM, V13 restarted R42's feeding pump at 85 mLs/hr (milliliters per hour). R42 was observed with wet, gargly cough again. V13 and V14 then left R42's room. Eight minutes later at 9:58 AM, V5 (LPN/Licensed Practical Nurse) entered R42's room, checked that his tube feeding had been restarted, and walked back out of the R42's room. Surveyor then asked V5 (LPN) to come back into R42's room to the side of his bed to assess the elevation angle of the head of R42's bed. V5 said it was not raised high enough for continuous tube feeding administration, adding R42's head of bed should be elevated to 45 degrees.</p> <p>R42's POS (Physician Order Sheet) shows an order dated February 21, 2025 saying to keep head of bed elevated at least 45 degrees to prevent aspiration. An additional order dated February 20, 2025 showed Aspiration Precautions. R42's Face Sheet shows he has a history of dysphagia, acute respiratory failure with hypoxia and hypercapnia on February 11, 2025, and Influenza A with pneumonia on February 11, 2025. R42's Care Plan dated February 22, 2025 says he receives nutrition/hydration through tube feeding related to diagnosis of dysphagia. R42's Goal states he will receive adequate nutrition without side effects associated with tube feedings (aspiration, etc).</p> <p>On February 27, 2025 at 10:04 AM, V10 (LPN) said R42's head of bed should be 45 degrees to prevent aspiration, per R42's physician orders. V10 said if R42's head of bed is not above 45 degrees while tube feeding is infusing, there is greater risk of the feeding coming up the esophagus and the resident choking/aspirating the feeding into the lungs.</p> <p>(continued on next page)</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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On February 27, 2025 at 1:15 PM, V2 (DON/Director of Nursing) said an aspiration precaution order means the staff should be paying attention to the angle of the head of bed. V2 said 20 degrees is not high enough for the head of the bed for a resident with aspiration precautions who is receiving continuous tube feeding. V2 said she would expect that the physician order stating to keep the head of bed 45 degrees would be followed. V2 said residents with tube feedings are at greater risk for aspiration because of their impaired swallowing and the risk of backflow of the tube feeding leading to regurgitation/aspiration.</p> <p>The facility's policy titled, Enteral Tube Feeding via Continuous Pump last revised November 2018 states, Purpose: The purpose of this procedure is to provide a guideline for the use of a pump for enteral feedings. Preparation .2. Review the resident's care plan and provide for any special needs of the resident .Steps in the Procedure .4. Position the head of the bed at 30-45 degrees (semi-Fowler's position) for feeding, unless medically contraindicated .</p> <p>46409</p> <p>2. On February 26, 2025 at 1:56 PM, V5 (LPN) went to R4's room to administer her medication and a GT feeding. V5 attached the syringe without the plunger to R4's GT port, and poured 30 ML of water into the syringe. V5 did not check for placement by aspirating any gastric content or checking residual volume prior to infusing the fluid.</p> <p>R4's face sheet showed she was admitted to the facility with diagnoses including attention to gastrostomy, bipolar disorder, dementia, gastroesophageal reflux disease, and dysarthria and anarthria. R4's MDS dated [DATE] shows she had severe cognitive impairment.</p> <p>On February 27, 2025 at 11:21 AM, V15 (RN/Registered Nurse) said nurses checked for placement by gravity. V15 said they would connect the syringe to the port, hold the syringe close to the resident's abdomen, and wait to see if any gastric content comes back into the syringe. V15 said she would wait one to two minutes to see if anything comes up to check for placement.</p> <p>On February 27, 2025 at 11:25 AM, V16 (RN) said they do not push air bubbles through the syringe or aspirate gastric contents to check for GT placement as it could cause a rupture of the GT. V16 said they check for placement by flushing the GT with water and watching it drain by gravity.</p> <p>On February 27, 2025 at 11:43 AM, V10 (LPN) said she does not aspirate to check for placement and would flush with water before administering formula or medications.</p> <p>On February 27, 2025 at 12:04 PM, V2 (DON/Director of Nursing) said they check for placement by gravity, and if there was any resistance with the initial flush, they would stop the procedure and call the doctor. V2 said aspirating or putting air causes more discomfort to the stomach, so they use the natural process of gravity. V2 said if the GT catheter dislodged or was not properly placed, nothing would infuse down the tube. V2 said they used to aspirate for gastric content, but their practice changed. V2 said she did not remember when the practice changed and would look for literature showing this practice was acceptable, which she was unable to provide.</p> <p>(continued on next page)</p> | | |

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| <p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The Equipment and Supplies portion of the facility's Enteral Tube Feeding Via Continuous Pump Level III policy (revised November 2018) included 9. pH strips and 10. Stethoscope. The Steps in the Procedure section of the policy showed 8. Verify placement of tube. 9. If anything suggests improper tube positioning, do not administer feeding or medication . 10. When correct tube placement has been verified, flush tubing with at least 30 mL warm water (or prescribed amount) . The policy does not include specific procedural steps for checking for GT placement, and it does not specify what is to be done with either the pH strips or the stethoscope.</p> <p>3. On February 26, 2025 at 1:01 PM, V5 (LPN/Licensed Practical Nurse) went to R43's room to administer his GT formula feeding. R43 attached the syringe without the plunger to R43's GT port marked feed and began by pouring 120 ML (Milliliters) of water into the GT. V5 did not check for placement by aspirating any gastric content or checking residual volume.</p> <p>R43's face sheet showed he was admitted to the facility with diagnoses including attention to gastrostomy, Parkinson's disease without dyskinesia, severe protein-calorie malnutrition, and cognitive communication deficit.</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003</p> <p>Based on observation, interview and record review, the facility failed to investigate a resident's continued complaints of chest pain to identify the cause.</p> <p>This applies to 1 of 1 resident (R157) reviewed for pain in a sample of 19.</p> <p>Findings include:</p> <p>R157 admitted to the facility on [DATE] for orthopedic after care following the surgical repair of a left hip fracture. On 02/25/25 at 11:45 AM, R157 was lying across the bed with his feet dangling off the bed. V23 (Physical Therapy Assistant) was attempting to place R157's feet back in the bed. V23 stated R157 was complaining of chest pain. V23 stated he would inform the nurse of R157's complaint of chest pain. R157 face was grimaced and he did not respond to surveyor's questions.</p> <p>On 02/25/25 at 11:48 AM, V18 RN (Registered Nurse) came to R157's bedside. V18 stated R157 fell a couple of days ago and has been complaining of chest pain since then. V18 stated she would speak to the NP (Nurse Practitioner) about the chest pain.</p> <p>On 02/26/25 at 11:13 AM, V19 RN stated she had just sent R157 to the hospital for his complaint of chest pain at 9:44 AM. He had been complaining of sternal and left chest / shoulder pain. V19 stated R157 was given pain medication overnight for his complaints of pain. V19 stated the report she received was that R157 had been yelling out since he came back to the facility on Sunday 2/23/25. V19 stated R157 was sent back to the hospital on Sunday after his fall in the facility and he had been complaining about his chest pain for days. V19 stated R157 had been medicated for his pain and the doctor thought it was muscular. V19 stated R157 had been rating his pain 10-11 out of 10 and he was still complaining of the pain after he received pain medication. V19 stated she had a call out to the doctor this morning to update him about the resident's pain. V19 stated while I was waiting for the doctor's return call, R157's wife called me stating R157 told her he was being sent to the hospital. V19 stated she did not tell R157 he was being sent back to the hospital and there was no plan to send R157 back to the hospital. V19 stated because R157 told his wife he was being sent to the hospital, the doctor said to send him out.</p> <p>On 02/27/25 at 11:56 AM, V20 (NP) stated R157 is not her regular patient, but V18 (RN) had asked her to address his complaint of chest pain. V20 stated she look at R157's records and saw he was sent out for chest pain. V20 stated she did not see any documentation of findings for R157's emergency room visit on 2/23/25. V20 stated when she spoke to R157, he stated he had rib pain with deep breathing and coughing. V20 stated per V18, the chest CT (Computed Tomography) was done and was negative. V20 stated because of those reasons, she did not order an X-ray. V20 stated she believed R157's pain was muscular.</p> <p>(continued on next page)</p> | | |

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| <p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 02/27/25 at 02:27 PM, V2 DON (Director of Nursing) stated on Sunday 2/23/25, R157 was sent to the hospital after a fall, and based on the imaging that was done, noting was found. V2 stated they did a CT scan of his abdomen and pelvis and a hip X-Ray, that were negative. V2 stated V19 (RN) informed her R157 was continuously complaining about his chest pain, and if a patient is complaining of chest pain, we get their description of the pain and vital signs, talk to the doctor and send them to the hospital. V2 stated if the chest pain is a new onset of chest pain, we send them out immediately. V2 stated when R157 initially complained of chest pain, we sent him to the emergency room , and they sent him back. V2 stated she did not know if a sufficient work up was done. V2 stated she believed the nurses thought because he was sent out and evaluated by the emergency room , his concerns had been addressed. V2 stated they would trust the emergency room worked R157 up correctly. V2 stated R157 was sent back to the emergency room three days later on 2/26/25, when it was discovered that R157 actually had a sternal fracture. V2 stated R157's rehabilitation will be more complex now with the sternal fracture in addition to his hip fracture.</p> <p>On 02/27/25 at 01:01 PM, V21 (Physical Therapist) stated for a resident with a sternal fracture, we try to avoid that area and do deep breathing to improve the lung capacity. V21 stated if it is not a recent fracture, we have the resident brace the sternal area to improve mobility and prepare the patient for their ADLs (Activities of Daily Living). V21 stated we check the medical records for any information regarding fractures. V21 stated the resident's pain could be increased if we move them without knowledge of the fracture and they may begin to refuse therapy. V21 stated if we transfer them incorrectly and they have a fracture we are unaware of, their fracture could become aggravated and worsen.</p> <p>On 02/27/25 at 03:37 PM, V22 MD (Medical Doctor) stated he last saw R157 on Monday 2/24/25. V22 stated he believed R157 was complaining of pain everywhere, mostly his lower body. V22 stated the pain complaints were peculiar because R157 was already receiving a high hydrocodone/acetaminophen. V22 stated he would expect staff to call 911 for residents that have complaints of chest pain.</p> <p>Nursing progress notes by V18 (RN) on 2/24/25 at 1:33 PM showed R157 complained of pain in both arms and chest area. R157 denied shortness of breath, nausea, vomiting and diarrhea. Pain mediation given. Seen by NP. Vital signs- NP ordered calcium carbonate.</p> <p>Hospital emergency room records dated 2/26/25 showed a fracture of the mid sternum.</p> <p>The facility provided policy Pain -Clinical Protocol (dated October 2022) states the physician will help identify causes of pain; for example, by examining the resident directly, reviewing the resident's history, and via discussion with the resident and staff .</p> | | |

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| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45906</p> <p>Based on interview, and record review, the facility failed to ensure proper care for resident receiving hemodialysis.</p> <p>This applies to 1 resident (R27) reviewed for dialysis in a sample of 19.</p> <p>The findings include:</p> <p>On 2/25/25 at 9:52 AM, V1 (Administrator) and V2 (DON/Director of Nursing) said they do not have any residents currently receiving Dialysis.</p> <p>On 2/25/25 at 11:49 AM, it was noted that R27 was at a dialysis center outside the facility, receiving dialysis. On 2/26/25 at 10:02 AM, R27 said she goes to outside facility for dialysis every Tuesday, Thursday, and Saturday. R27 showed surveyor her right upper chest access port that is used for dialysis.</p> <p>R27's Face Sheet shows she was admitted to the facility on [DATE] with primary diagnoses of end stage renal disease (ESRD) and history of dependence on renal dialysis. R26's Care Plan dated 1/9/25 states she goes to hemodialysis on Tuesday, Thursday, and Saturday.</p> <p>On 2/26/25 at 1:45 PM, V1 (Administrator) said she did not have a current dialysis contract that she could provide to the Surveyor. V1 said she was working on getting an agreement because she knew she needed one.</p> <p>On 2/27/25 at 9:40 AM, V10 (LPN/Licensed Practical Nurse) said R27 just left to go to dialysis. On 2/27/25 at 10:26 AM, V1 said she still could not provide surveyor with a dialysis agreement/contract. V1 said dialysis agreements are a requirement because they ensure the resident's safety by having in writing a mutual understanding of the services the facility is providing and the services the dialysis facility is providing and any liability that may be imposed. V1 said she did not have a hemodialysis policy.</p> <p>On 2/27/25 at 12:27 PM, V10 (LPN) said the only required communication between the facility and Dialysis is the completion of the Dialysis Communication Form in the Dialysis binder kept at the nurse's station. V10 said the facility staff complete the top portion of the form labeled Pre-Dialysis and the dialysis facility will then fill out the bottom portion labeled Dialysis and send it back to the facility with the resident after completion of that day's dialysis.</p> <p>R27's dialysis binder contained six Dialysis Communication Forms that were not completed since admission: 1/30/25, 2/4/25, 2/8/25, 2/11/25, 2/15/25, and 2/18/25. There was also no Dialysis Communication Form from 2/25/25.</p> <p>(continued on next page)</p> | | |

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| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 2/27/25 at 1:15 PM, V2 (DON) said a dialysis contract/agreement is required to establish communication and continuum of care for the dialysis resident. V2 said the communication that is expected between the facility staff and dialysis staff is the completion of the Dialysis Communication Form. On 2/27/25 at 2:03 PM, V11 (Dialysis Center Nurse) said communication takes place on the Dialysis Communication form in which the top portion is filled out by the facility and the bottom is filled out by Dialysis Center staff. V11 said if there is any change in the resident's medications or the resident gets sent to the hospital, the Dialysis staff will call the facility to update them, otherwise they only communicate by the Dialysis Communication Form.</p> <p>The facility's policy titled, End-Stage Renal Disease, Care of a Resident with (revised September 2010) states, Policy Statement: Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. Policy Interpretation and Implementation . 4. Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including: a. how the care plan will be developed and implemented; b. how information will be exchanged between the facilities; and c. responsibility for waste handling, sterilization and disinfection of equipment. 5. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/Dialysis care .</p> |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46380</p> <p>Based on observation, interview and record review, the facility failed to dispose of expired house stock medications from the medication room.</p> <p>This has the potential to affect all 58 residents in the facility.</p> <p>The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 2/25/2025 to 2/28/2025 showed a census of 58 residents.</p> <p>The findings include:</p> <p>On 2/26/2025 at 10:45 AM and 2/27/2025 at 10:45 AM, inspection of the facility's medication room showed the following expired house stock medication:</p> <p>Four boxes of hemorrhoidal cream that expired on 11/2024. A tube of expired hemorrhoidal cream was found inside the medication cart in the north hall.</p> <p>Four bottles of Elder Tonic that expired on 7/2024.</p> <p>Seven boxes of Diphenhydramine 25 mg (100 capsules/box) that expired on 11/2024</p> <p>Two bottles of Oyster Shell Calcium 500 mg plus Vitamin D tablet (1000 tablets) that expired on 10/2024.</p> <p>On 2/26/2025 at 11:00 AM, V5 (LPN-Licensed Practical Nurse) said the night nurse checks the medication room and is responsible for discarding expired medications.</p> <p>On 2/26/2025 at 12:30 PM, V2 (DON-Director of Nursing) said it was the night supervisor's responsibility to make sure the medication room is organized and expired medications are disposed of. On 2/27/2025 at 1:45 PM V2 said expired medications should be disposed of promptly so there is no chance of them being administered to a resident. She said if medication is expired, medication has less potency. She said the proper process of disposing of expired medication is to send medication, including house stock, back to the pharmacy to be destroyed.</p> <p>The facility's Medication Labeling and Storage Policy (revised February 2023) states if the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>46409</p> <p>Based on observation, interview, and record review, the facility failed to follow guidelines for Personal Protective Equipment (PPE) use and handwashing.</p> <p>This applies to 4 of 4 residents (R4, R256, R43, R209) reviewed for infection control in a sample of 19.</p> <p>The findings include:</p> <p>1. On February 25, 2025 at 9:29 AM, V7 (CNA) went to assist R256 and did not apply the face shield before entering R256's room. R256 was on contact isolation, droplet isolation, and EBP (Enhanced Barrier Precautions) due to being positive for COVID-19. R256's isolation signages showed the staff should wear a gown, gloves, N95 respirator mask, and a face shield prior to entering the room. At 9:30 AM, V6 (CNA) also entered R256's room without applying a face shield.</p> <p>R256's face sheet showed he was admitted to the facility with diagnoses including COVID-19.</p> <p>On February 27, 2025 at 11:39 AM, V7 said she should wear a gown, N95, face shield, and gloves before entering a COVID-19 positive room. V7 said not wearing the appropriate PPE (Personal Protective Equipment) could expose her to COVID-19 and she could also spread the infection to other residents.</p> <p>On February 27, 2025 at 11:34 AM, V17 (CNA) said for COVID-19 isolation, the staff should wear an N95 mask, gown, gloves, and goggles or face shield. V17 also said she would wear a gown, gloves, and a mask for residents on EBP. V17 said when she provided incontinence care, she would clean her hands upon entry of the resident's room and after she had completed providing incontinence care, prior to leaving the room.</p> <p>On February 27, 2025 at 11:25 AM, V6 (RN) said for residents under COVID-19 isolation, the staff should wear an N95 mask, gown, face shield, and gloves. V6 said for residents on EBP, the staff should wear a gown and gloves. V6 also said for incontinence care, the staff should change their gloves and wash their hands before touching the clean items.</p> <p>The facility's Coronavirus Disease (COVID-19)- Using Personal Protective Equipment policy revised September 2022 showed Personnel who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection adhere to standard precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection.</p> <p>2. On February 26, 2025 at 1:50 PM, R43's room was on EBP (Enhanced Barrier Precautions), with signage for EBP and an isolation cart outside his room containing gowns and gloves. R43 was in the bathroom and V4 (CNA) was wiping R43's perianal area and was not wearing a gown.</p> <p>On February 26, 2025 at 1:52 PM, V4 said R43 was only on precautions for handwashing. V4 then looked at R43's EBP signage and said she should have worn a gown, gloves, and a mask when taking him to the bathroom.</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145606 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/28/2025 |
| NAME OF PROVIDER OR SUPPLIER Covenant Living - Windsor Park | | STREET ADDRESS, CITY, STATE, ZIP CODE 110 Windsor Park Drive Carol Stream, IL 60188 | |
| 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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>R43's face sheet showed he was admitted to the facility with diagnoses including attention to gastrostomy, Parkinson's disease without dyskinesia, severe protein-calorie malnutrition, and cognitive communication deficit.</p> <p>The facility's Enhanced Barrier Precautions revised August 2022 showed Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: providing hygiene; changing briefs or assisting with toileting .</p> <p>3. On February 26, 2025 at 9:35 AM, V6 (CNA/Certified Nurse Assistant) provided incontinence care for R4. V6 wiped R4's perineal area, tucked the dirty incontinence brief and incontinence pad underneath R4 and then placed the clean brief and pad underneath her using the same soiled gloves. V6 then said R4 had a bowel movement, so wiped her again, went to the bathroom and turned on the water but did not perform hand hygiene with soap and water or alcohol-based hand sanitizer, and applied new gloves. V6 then grabbed a clean brief and placed it under R4 and affixed her brief. V6 went into the bathroom again, turned on the water, but did not wash her hands with soap and water or alcohol-based hand sanitizer before applying new gloves. V6 returned to the resident and fixed her blanket. V6 then returned to the bathroom again, turned on the water, and did not wash her hands with soap and water or use alcohol-based hand sanitizer, and applied new gloves. V6 said she should have washed her hands with each of the glove changes.</p> <p>The facility's Handwashing/Hand Hygiene policy revised August 2019 showed Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: Before and after direct contact with residents; after contact with blood or bodily fluids; After removing gloves .</p> <p>46380</p> <p>4. On February 27, 2025 at 9:22 AM, V8 (CNA-Certified Nurse Assistant) provided incontinence care to R209. While providing care, V8 wore gloves and surgical mask. After providing incontinent care and putting on R209's clothes, V8 informed R209 she was stepping out of the room to call another staff to help her with transfer.</p> <p>On February 27, 2025 at 9:59 AM, V8 came back to R209's room with V9 (CNA). V8 and V9 were only wearing gloves and surgical masks. V8 and V9 straightened out R209's clothing and proceeded to transfer R209 using a mechanical lift.</p> <p>R209's EHR (Electronic Health Record) documents she is on Enhanced Barrier Protection (EBP) for surgical wounds. R209's wound is on her right hip. R209's door had a sign stating she is on EBP.</p> <p>On February 27, 2025 at 10:57 AM, V3 (ADON-Assistant Director of Nursing/IP-Infection Preventionist) said staff should wear gloves, gowns and mask when entering enhance barrier precaution room to provide care. She said if there is a chance for splashing, staff should wear a face shield as well. She said all staff are expected to wear appropriate PPE (Personal Protective Equipment). She said the purpose for wearing appropriate PPE is to protect resident.</p> | | |