STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146110	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smith Crossing	10501 Emilie Lane Orland Park, IL 60467

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 46409 Based on observation, interview, and record review, the facility failed to assess whether a resident was able to administer medications independently. This applies to 1 of 1 resident (R419) reviewed for self-administration of medications in a sample of 20. The findings include: On June 25, 2024 at 12:20 PM, during initial tour, R419 was in her room and a Ventolin inhaler was found on her bedside table. R419 said she took two puffs a day and had already done it earlier. On June 26, 2024 at 9:41 AM, R419's Ventolin inhaler was sitting on her bedside table. On June 26, 2024 at 1:07 PM, V8 (RN/Registered Nurse) said residents were allowed to self-administer medications if the doctor approved them to administer certain medications at the bedside. V8 said she did not believe she had any residents who were allowed to have medications at bedside. V8 said she was taking care of R419. V8 said residents who were not approved to have medications at bedside could end up doubling up on the dose or someone else could take it. V8 said if a resident wanted to self-administer, she would notify the manager, and they would do an assessment to see if they were safe to self-administer. V8 said she would then call the doctor and get a clearance and an order needed to be in the computer. V8 said even if they were allowed to self-administer, the nurses needed to be present to supervise the administration. On June 27, 2024 at 2:49 PM, V2 (DON/Director of Nursing) said the residents are allowed to have medications at the bedside if there is an order in the computer and an assessment should be found under Assessments in the EMR (Electronic Medical Record). R419's POS (Physician Order Sheet) showed an order for Ventolin two puffs to be administered every six hours; R419's POS did not have an order to self-administer medications. The facility was also unable to provide a self-administration assessment or progress notes showing R419 was safe to self-administer medications. R419's care plans were reviewed, and there was no information about whether R419 was safe to self-administer medications. The facility's Facility Responsibilities - Resident Rights policy reviewed on February 2024 showed The resident has the right to self-administer medications if the interdisciplinary team [IDT] has determined that this practice is clinically appropriate. A resident may only self-administer medications after the IDT has determined which medications may be self-administered .The resident's ability to ensure that medication is stored safely and securely.

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384 Based on observations, interviews, and record reviews the facility failed to provide privacy during personal cares. This applies to 4 residents (R29, R45, R117, & R418) reviewed for privacy in a sample of 20. Findings include: 1. On 06/26/24 at 1:52 PM V20 CNA (Certified Nurses' Assistant) and V21 (Nurse) were providing wound care and incontinence care for R29 while the blinds to R29's window were open, and you could see the patio area outside. During incontinence care, V21 left R29's room to get antifungal cream from the medication cart and V21 left R29's door open while R29 was in the bed with her buttocks exposed. R29 was in view of anyone walking down the hall. On 06/27/24 at 1:39 PM, the surveyor, V2 DON (Director of Nursing), & V23 ADON (Assistant Director of Nursing) went outside to the courtyard area and was able to see in R29's window. On 06/27/24 at 12:55 PM, V2 (DON) said that the staff should have closed the door and blinds while providing care to R29 for R29's dignity. V2 said that the staff doesn't know who is in the courtyard or in the hallway. The facility's Perineal Care dated March 2024 showed provide privacy by pulling privacy curtain or closing room door if a private room. 2. On 06/25/24 at 12:40 PM, during dining room observations, V5 (Nurse) walked over to R117 and picked up R117's glass of water and glass of lemonade, bringing them closer to R117 and said very loudly to R117 to drink his water and lemonade so he doesn't get another UTI (urinary tract infection). V5 then said to R117 that he gets them often. This observation was made by the surveyor while the surveyor was in the doorway between the dining room and the kitchen and R117 was sitting at the table in the dining room. R117's electronic health record showed that he is an [AGE] year old male who was admitted to the facility on [DATE] with diagnoses including UTIs, Type 2 diabetes, dementia, cerebrovascular disease, & hypertension. On 06/27/24 at 12:57 PM, V2 (DON) said that V5 should not have said that to R117 in a public place for his dignity. V2 said that it is R117's personal information. V2 said that it is in the facility's Resident's Rights policy. V2 never provided the surveyor with the facility's Residents' Rights policy. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 06/26/24 at 12:34 PM to 12:55 PM, V30 (Nurse) was observed giving R45 his medications and G-tube (gastric tube) feeding while R45's bedroom door, privacy curtains and window blinds were open. During this time, R41 (roommate of R45) was present, and R45 was exposed from his waist to his lower chest. V30 was observed twice during this time talking to staff while the staff stood in R45's doorway. V30 and R45 were observed looking out the window at the maintenance worker hooking up the garden hose next to R45's window. On 06/27/24 at 01:07 PM, V2 (DON) said that V30 should have closed the door, privacy curtains, and window blinds to insure R45's privacy. The facility's March 2023 Promoting/Maintaining Resident dignity policy showed under 10. Speak respectfully to residents; Avoid discussions about residents that may be overheard. 12. maintain resident privacy. 4. On June 25, 2025 at 11:27 AM, R418 was receiving incontinence care from V6 (CNA/Certified Nurse Assistant). R418's room was on the first floor and her window blinds were open. V6 removed R418's blanket, pants, and incontinence brief while the window blinds were open. On June 26, 2024 at 2:22 PM, V6 said she needed to close the blinds and doors for incontinence care because they need to provide privacy for the resident. V6 said she would still close the blinds for residents if they were not alert or oriented. On June 26, 2024 at 2:29 PM, V7 (CNA) said if she was providing incontinence care, she would ask anyone in the room to step out, she would close the door, and close the blinds. On June 27, 2024 at 2:49 PM, V2 (DON/Director of Nursing) said the staff should close the door and blinds when providing incontinence care to residents. R418's face sheet showed she was admitted to the facility on [DATE] with diagnoses including urinary tract infection, generalized anxiety disorder, acute kidney failure, Stage 3 chronic kidney disease, anemia, gastroesophageal reflux disease, glaucoma, and retention of urine. R418's MDS (Minimum Data Set) was not available as R418 was a new admission. The facility's Promoting/Maintaining Resident Dignity policy last reviewed in March 2024 showed It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality .Maintain resident privacy.

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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** 41384 Based on interview and record review, the facility failed to provide the facility's bed hold and bed payment policy in writing to a resident and their representative before transferring to the hospital. This applies to 1 of 3 residents (R66) reviewed for discharge in a sample of 20. Findings include: R66 is a [AGE] year old male admitted to the facility on [DATE] and transferred to the local community hospital on 4/5/24. R66 had diagnoses including urinary tract infection, metabolic encephalopathy, congestive heart failure, hypothyroidism, and hypertension. R66's 4/5/24 9:36 PM Nurse Practitioner progress note showed that R66 was only arousable briefly by sternum rub and was transferred to the local community hospital via 911. The notes showed that V32 (R66's wife) was at bedside. There was no documentation showing that the resident or resident's representative was given the facility's bed hold and bed payment policy. R66's 4/5/24 8:04 PM Nursing progress note did not show that R66 or his representative was given the facility's bed hold and bed payment policy at the time of transfer to local community hospital. On 06/27/24 at 10:02 AM, V2 DON (Director of Nursing) said that the facility had no proof that the bed hold policy had been given to R66 or his family, but it is the facility's policy to give it. On 06/27/24 10:21 AM V19 (Social Service Director) said that it is the facility's policy for the nurse to remind the residents of the bed hold policy when they are being transferred to the hospital. V19 said that the facility's policy only says to provide notice. V19 said that the policy doesn't say give a hard copy. On 06/27/24 at 01:20 PM, V2 said that residents and or residents' representatives receive a bed hold policy on admission and they should receive one when they are transferred to hospital. V2 said that the facility only notifies that they are being transferred to the hospital. V2 said that there was no documentation for R66 receiving the facility bed hold policy or even saying that the nurse reminded R66, or representative, of the facility's bed hold policy. The facility's Transfer and Discharge policy dated 2/24 showed under 12. Emergency Transfer/Discharge -F. Provide notice of transfer and the facility's bed hold policy to the resident and representative as indicated.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on observation, interview and record review, the facility failed to provide wound dressing changes as per physician's order. This applies to 1 of 4 residents (R64) reviewed for skin conditions in a sample of 20. Finding include: R64's Face Sheet showed R64 was admitted to the facility on [DATE] with diagnoses of cerebral infarction, cellulitis of left and right lower limbs, morbid obesity, poly-osteoarthritis, muscle wasting, chronic venous hypertension with ulcer of lower extremities R64's current lower extremity dressing change physician's orders are to wash with soap and water, and dry, apply ordered cleanser to all open wounds, apply non adhering dressing, abdominal pad secure with rolled gauze. Change every other day four times per week and as needed. R64's care plan states R64 is at risk for skin break down related to fragile aging skin. Interventions include administer prescribed medications and treatments per doctor's orders. Weekly skin assessments observe for signs of infection such as redness, inflammation, drainage and notify the physician as necessary. Document wound care, wound status, healing process in accordance with facility protocol. On 06/27/24 at 11:05 AM, R64's dressing change was observed being done by V21 (Wound Nurse) and V20 (Certified Nursing Assistant-CNA). R64's right and left lower extremities were wrapped with roll gauze from knee to ankle dated 6/25/24. R64's left lower extremity dressing was completely soaked through on the back with a copious amount of yellow/pale green drainage. The right lower extremity dressing had a yellow silver dollar sized area of drainage present . R64's right and left lower extremities were covered with white crusty scaled skin. R64 had red ulcerations on both lower extremities. On 06/27/24 at 1:41 PM, V2 DON (Director of Nursing) stated nurses change dressing according to the physician order. If the wound nurse is not here, the nurse that is assigned to the resident should change the dressing if necessary. If a dressing is visibly soiled, coming apart, or no longer in place and covering the wound, it would need to be changed. The person caring for the resident or whoever notices it should notify the nurse if a dressing soiled and soaked through. If R64's dressing was soaked through, we should probably be changing it more frequently. On 06/27/24 at 3:30 PM, V21 Wound Nurse stated R64's dressing changes are done three times per week on Tuesday, Thursday, Saturday and as needed. R64's dressing change should have been done before I saw her today considering the amount of drainage that was on it. The dressing change order has been in place for the month she has been in the facility. Her leg could have become macerated sitting in a wet dressing. I only do documentation by exception I did not document any drainage or condition of the wound on just the dressing change on the treatment record. The doctor did some documentation on her wound size and description. I've done some notations somewhere but I'm not sure where it is. On 06/27/24 at 4:24 PM, V2 DON stated the wound nurse absolutely should be doing documentation describing the wound and drainage as part of her wound assessment and documentation wounds dressings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Two nursing notes were provided documenting a description of R64's lower extremity dressing changes dated 5/17/24 and 6/14/24. The facility policy Wound Treatment Management dated March 2024 states wound treatments will be provided in accordance with physician's orders, including cleansing method, type of dressing and frequency of dressing change. Dressing changes maybe provided outside the frequency parameters in certain situations: the dressing is soiled otherwise or is wet.

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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** 46003 Based on observation, interview and record review, the facility failed to store oxygen cylinders in a manner to prevent possible explosion hazards, and failed to transfer a resident using a gait belt. This applies to 4 of 4 residents (R25, R59, R64 and R418) reviewed for safety hazards in a sample of 20. Findings include: 1. On 06/25/24 at 10:54 AM, a portable oxygen cylinder was observed in R25's room. The oxygen cylinder was not in a stand or tethered. R64 and R59 are in the rooms on either side of R25's room and at risk of injury if cylinder tips over and explodes. On 06/25/24 at 12:39 PM, V33 (Certified Nursing Assistant/CNA) stated she did not know who placed the oxygen cylinder in R25's room. V33 stated the teaching she received regarding oxygen storage was it should be stored in a cool room and turned off when not in use. On 06/25/24 at 12:55 PM, V34 (Registered Nurse/RN) stated she saw the cylinder in R25's room not in a holder or tethered. V34 stated the oxygen cylinders should be kept in a holder or on the back of a wheelchair because if it tips over the cylinder can be damaged and need to be replaced. On 06/25/24 at 1:04 PM, V35 (RN Supervisor) stated oxygen cylinders should be in a holder or tethered to keep them from falling and causing injuries from an explosion. On 06/26/24 at 2:06 PM, an oxygen cylinder at 200 psi (pounds per square inch) was in R25's room. The cylinder was not in a stand or tethered. On 06/26/24 at 2:09 PM, V35 (RN Supervisor) was made aware of the oxygen cylinder in R25's room. On 06/26/24 at 5:19 PM, V2 DON (Director of Nursing) stated oxygen cylinders should not be free-standing; they should be in a holder or tethered. V2 stated oxygen is flammable. If it tips over, it could combust. It could also fall on someone's foot and cause an injury. The facility policy Oxygen Safety dated December 2023 states when small size cylinders are in use, they shall be attached to a cylinder stand or medical equipment designed to receive and hold compressed gas cylinders. 46409 2. On June 25, 2024 at 11:18 AM, V6 (CNA) assisted to transfer R418 from the wheelchair to the bed. V6 faced R418's wheelchair at an angle to the bed, and then pulled R418 up by the waistband of her pants and pivoted her onto the bed. V6 did not apply or use a gait belt. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On June 26, 2024 at 2:22 PM, V6 said she had helped R418 transfer by pulling her pants. V6 said she was supposed to use a gait belt to ensure the resident did not fall. At 2:29 PM, V7 (CNA) said the staff should be using a gait belt and walker for extra balance, and the staff should not be pulling the residents up using their pants. On June 26, 2024 at 2:12 PM, V10 (PTA/Physical Therapy Aide) said R418 was weight bearing as tolerated and required a two-person assistance to transfer at this time. V10 said the staff should be using a gait belt because R418 was a high fall risk and had poor postural control, so there should be two staff present for her transfer. V10 said the staff should not be pulling the residents by their pants and have all been trained on using a gait belt. On June 27, 2024 at 2:49 PM, V2 (DON/Director of Nursing) said the staff should be using gait belts to transfer the residents and should not be transferring the residents by holding their pants. R418's face sheet showed she was admitted to the facility on [DATE] with diagnoses including urinary tract infection, generalized anxiety disorder, acute kidney failure, Stage 3 chronic kidney disease, anemia, gastroesophageal reflux disease, glaucoma, and retention of urine. R418's MDS (Minimum Data Set) was not available as R418 was a new admission. The facility's Safe Resident Handling policy reviewed on March 2024 showed Gait (transfer) belt usage is mandatory for all residents with the exception, of bed mobility and medical contraindication. When using a gait belt, use a pivoting technique.

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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. 45906 Based on observation, interview, and record review, the facility failed to ensure a resident received oxygen therapy consistent with how the device was designed to deliver it per physician orders. This applies to 1 of 4 residents (R15) reviewed for respiratory care in a sample of 20. On 6/25/24 at 12:14 PM, R15 was sitting at a table in the dining room with her nasal cannula crooked on her face; one nasal prong was in her right nostril and the other nasal prong was next to her right nostril on her right cheek. Her nasal cannula tubing was connected to a portable oxygen delivery device that was flashing orange with message no breathing detected, please check cannula. Surveyor counted R15's respiratory rate at 32 breaths per minute. Surveyor asked R15 if she was feeling and breathing okay and R15 did not answer. R15 was breathing fast, but she was not mouth breathing or gasping for air. At 12:19 PM, surveyor pointed out the no breathing detected message to V4 (CNA/Certified Nurse Assistant) and V4 said she did not know what the message meant and she would have to ask the nurse. V4 (CNA) then continued to feed R15 with the nasal cannula crooked on her face and the oxygen delivery device not working properly and V4 (CNA) did not notify R15's nurse. At 12:39 PM surveyor found R15's nurse, V3 (Registered Nurse/RN), and notified V3 of the no breathing detected message on the portable oxygen delivery device. At 12:41 PM, V3 (RN) switched R15's nasal cannula tubing to a portable oxygen tank and turned the dial to 3 liters. V3 did not check R15's oxygen saturation level or assess the nasal cannula to make sure it was positioned correctly in her nose. At 12:47 PM, surveyor told V4 (CNA) who was still sitting next to R15 that R15's nasal cannula prongs were not positioned in both nostrils and V4 then fixed the nasal cannula. At 12:50 PM, surveyor again assessed R15's respiratory rate and counted 24 breaths per minute. R15 appeared more comfortable. R15's Face Sheet shows admission diagnoses of chronic obstructive pulmonary disease, acute and chronic respiratory failure, pulmonary embolism, and cognitive communication deficit. R15's MDS (Minimum Data Set) dated 5/10/24 shows her cognition is severely impaired and she requires continuous oxygen therapy. R15's POS (Physician Order Sheet) shows an order dated 5/10/2024 for continuous oxygen therapy per nasal cannula. R15's Care Plan with last evaluation date of 6/28/23 states R15 will be free from any signs of respiratory distress or any signs or symptoms of chronic obstructive pulmonary disease exacerbation. Interventions include to check oxygen saturation as needed and assess R15's respiratory rate and work of breathing. On 6/27/24 at 2:32 PM, V2 (DON/Director of Nursing) said R15's portable oxygen delivery device works differently than a portable oxygen tank. V2 said R15's portable oxygen delivery device would only deliver oxygen to R15 when she would breathe in. V2 said if the device was reading no breathing detected, please check cannula she would expect the staff to follow up and fix the problem immediately. V2 said a normal respiratory rate for an adult is 16-20 breaths per minute. V2 said she would expect that both the CNA and RN would have assessed R15's nasal cannula first to make sure it was positioned correctly in her nose. V2 said it is a problem if a nasal cannula is only positioned in one nostril because then the resident is not getting the physician prescribed dose of oxygen and this can lead to increased respiratory rate and work of breathing and eventually impact the resident's mental status if the oxygen is not fixed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy last reviewed December 2023 titled, Oxygen Administration states, Policy: To establish a policy and procedure for the administration of oxygen therapy used to treat or prevent the symptoms and manifestation of hypoxia. Oxygen is administered to residents who need it, consistent with their comprehensive person-centered care plans, and goals and preferences . Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384 Based on observations, interviews, and record reviews, the facility failed to appropriately store medications and biologicals safely for 6 residents (R44, R15, R18, R45, R47, R6 and R418) in a sample of 20. Findings include: 1. On 06/26/24 at 09:54 AM an observation of V5's (Nurse) medication cart was being made with V5, and R44's alprazolam 0.5mg (milligram) medication card was observed having a count of 24 medications. The number 24 medication was observed opened and retaped closed. V5 said that the medication should have been discarded. V5 said that R44 never takes the medication from her, and she did not know when it was opened and retaped or when the last time R44 received the medication. R44's controlled Drug Receipt for Alprazolam 0.5mg showed that the last time the medication was given was on 6/17/24. R44's electronic health record showed that R44 is an [AGE] year old female admitted to the facility on [DATE] with diagnoses including anxiety disorder. R44's 6/12/24 physician's order showed, Alprazolam 0. 25mg (not 0.5 mg) as needed for 14 days. There was no order found for Alprazolam 0.5mg. On 06/26/24 at 10:02 AM, V2 DON (Director of Nursing) said that the medication should have been discarded because there is no evidence it is the same medication, and the medication can be contaminated if it has been touched by unclean hands or touches an unclean surface. 2-6. On 06/26/24 t 10:07 AM the facility's FH medication room refrigerator was observed with no thermometer and no temperature log. Inside the refrigerator was: 1 vial of TB (tuberculosis) vaccine, 1 E kit (Emergency Kit): containing insulins: 1 Levemir pen, 1 NPH pen, 1 NovoLog pen, 1 Lantus pen, 1 Humalog vial, 1 Humulin vial, 5 boxes and bags of Bisacodyl 10 mg suppositories for: R15, R18, R45, R47, & R6, & 2 boxes of acetaminophen 650mg suppositories for R18 & R6. On 06/26/24 at 01:35 PM, V2 verified that all the above medications were in the FH medication refrigerator. R15's EHR (electronic health record) showed that she is an [AGE] year old female admitted to the facility on [DATE]. R15's 5/9/24 physician order showed, Bisacodyl 10 mg PRN (as needed). R18's EHR showed that she is a [AGE] year old female admitted on [DATE]. R18's 10/3/23 physician order showed, Bisacodyl 10 mg suppository PRN & Acetaminophen 650 rectal suppository PRN. R45's EHR showed that he is a [AGE] year old male admitted on [DATE] to the facility. R45's 1/10/24 physician order showed, Bisacodyl 10 mg suppository PRN. R47's EHR showed she is an [AGE] year old female admitted on [DATE] to the facility. R47's 12/3/23 physician order showed, Bisacodyl 10mg suppository PRN. (continued on next page)

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	146110	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smith Crossing	10501 Emilie Lane Orland Park, IL 60467

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R6's EHR showed that she is a [AGE] year old female admitted to the facility on [DATE]. R6's 3/6/23 physicians orders showed, Bisacodyl 10 mg suppository PRN & Acetaminophen 650mg rectal suppository PRN. On 06/27/24 12:45 PM, V2 DON (Director of Nursing) said that R44's Xanax punch card should not have been taped back because of the possibility of contamination and possible drug diversion. V2 said that the facility does not know what drug is in the punch card now. V2 said that her expectations of the nurses are that if they punched it out, they are to waste it with another nurse. V2 said that there is supposed to be a thermometer inside the medication refrigerator and a temperature log. The temperatures are to be taken daily and logged by the night shift. V2 said this needs to be done because the medications need to be kept at a certain temperature and if not kept at that temperature, they are no longer able use them- it destroys the drug's integrity. V2 said that her expectations for the facility's nurses are that when there is any chance that the refrigerator is not working or they don't know if the temperature is out of range, get a new refrigerator or thermometer and call the pharmacy to see how long of a hold time is on the medications and discard anything that is not good to save. The facility's Facility Responsibilities - Resident Rights policy reviewed on February 2024 showed the facility must evaluate The resident's ability to ensure that medication is stored safely and securely. The facility's Medication Storage policy reviewed on March 2022 showed It is the policy of this facility to ensure all medications housed on our premises will be stored in the medication rooms to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security .All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. The facility's controlled substance Administration & Accountability policy dated March 2024 showed that it is the policy of the facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The policy showed that the facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. The facility's Storage of Medication Requiring Refrigeration policy dated March 2024 showed that it is the policy of the facility to ensure proper and safe storage of medication requiring refrigeration and to prevent the potential alteration of medication by exposure to improper temperature controls. Provide safe and effective storage of all drugs and biologics in a locked storage area under proper temperature control limited access. Ensure all medications and biologics will be stored at proper temperature and other appropriate environmental controls to preserve their integrity. Refrigerated temperature maintained between 36 to 46 F. Temperatures to be monitored daily to ensure proper temperature control and documented on the temperature log with date, time, and signature of person performing the check clearly written.

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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. 50501 Based on observation, interview, and record review, the facility failed to ensure the kitchen staff performed hand hygiene before handling clean dishes, and failed to ensure staff contained their hair during food preparation. This applies to 74 of 75 residents that consume food from the kitchen. The findings include: The facility's June 25, 2024, resident census report showed 74 residents consume food from the kitchen. 1. On June 26, 2024, at 11:31 AM, V18 (Dishwasher) loaded the dishwasher with dirty pots and utensils. Without washing hands or changing gloves, V18 went to the other end of dishwasher and removed dishes from the clean dish rack and placed the clean pans in drainer. With the same soiled hands, V18 placed the clean, dry utensils on the racks and hooks in the food preparation area, which was above the area the pureed food was being prepared. V18 then cleaned the transport cart with paper towels and was seen drying his gloved hands on a cloth towel. The facility's Hand Hygiene Policy dated March 2024 includes All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility . 2. On June 25, 2024, at 10:13 AM, V15 (Sous Chef) wore a cap with her hair not restrained in a hair net. V15 had hair hanging from back of the cap while preparing sauces and using the oven. On June 26, 2024, at 11:13 AM, V17 (Cook) wore a baseball cap with an unrestrained ponytail sticking out of the back of the cap. V16 (Cook) had a large, bushy beard that was not covered while preparing food. V18 (Dishwasher) also had an uncovered, large bushy beard. V12 (Food Service Manager) stated the facility did not have beard coverings available. On June 26, 2024, at 02:35 PM, V13 (Food Service Director) stated hair nets were required by everyone in the food preparation area. [NAME] covers should be worn by those staff who had facial hair while in the food preparation areas. V13 stated the facility did not have any beard covers currently available. The facility's January 2024 Uniform Dress Code policy showed .associates working with food should wear the approved hair restraints when on duty regardless of length or presence of hair It also showed associates are required to restrain all facial hair within a beard net restraint.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46409 Based on observation, interview, and record review, the facility failed to post and follow isolation precautions for residents under isolation; failed to perform hand hygiene during meal service, toileting, wound care, and incontinence care; and failed to safely handle soiled linen. This applies to 8 of 8 residents (R23, R29, R43, R44, R45, R117, R167, R418) reviewed for infection control in a sample of 20. The findings include: 1. On June 25, 2024, R418 was under EBP (Enhanced Barrier Precautions). Outside R418's room was the EBP signage, as well as an isolation bin with gowns, gloves, and face masks. At 11:24 AM, V6 (CNA/Certified Nurse Assistant) walked into R418's room with only gloves on and assisted R418 to transfer from the wheelchair to the bed. V6 took R418's urinary catheter bag and placed it on the ground during the transfer. At 11:28 AM, V6 picked the urinary catheter bag up from the ground and placed it into the privacy bag hanging on the bed frame. At 11:29 AM, V6 began assisting R418 with incontinence cares while wearing gloves but no gown. R418 had a bowel movement and V6 cleaned R418's bowel movement. At 11:33 AM, V6 observed excoriation and redness and said she was going to get the nurse. At 11:35 AM, V6 removed her gloves and left the room without performing hand hygiene. At 11:38 AM, V6 returned to the room with gloves on and V8 (RN/Registered Nurse) applied both the gown and gloves prior to entering the room. V6 began wiping R418's perianal area with wipes to show V8 R418's broken skin. V6 told V8 it was R418's second bowel movement for the day and both had been loose. V8 said R418 had labs done yesterday and she was going to check the results and notify the wound nurse of the irritated skin. V6 continued wiping R418's perianal area, removed her gloves, and applied new gloves without any hand hygiene. V6 wiped R418's catheter tubing to remove the stool. Wearing the same soiled gloves, V6 applied a new incontinence brief, then removed her gloves and left the room and used alcohol-based hand sanitizer. At 11:54 AM, V6 and V8 returned to R418's room wearing gloves but no gowns. V6 and V8 repositioned R418 and then both removed their gloves. At 11:59 AM, V8 picked up R418's urinary catheter bag without gloves on to see how much urine was in the collection bag. At 11:59 AM, V8 used hand sanitizer inside the room, and V6 left the room without performing any hand hygiene. On June 26, 2024 at 9:27 AM, R418 was observed to under contact isolation. R418's isolation signage showed alcohol-based hand sanitizer was an appropriate hand hygiene method after exiting from R418's room. At 11:44 AM, V36 (Family Member) said R418 had tested positive for Clostridium Difficile (C. Diff.). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On June 26, 2024 at 2:35 PM, V9 (CNA) entered R418's contact isolation room with a gown on and no gloves. At 2:36 PM, V9 exited R418's room after removing her gown and walked to the end of the hallway where another isolation bin was located, and grabbed an unopened package of gowns and put the package of gowns in R418's isolation bin. V9 then grabbed a new gown without performing any hand hygiene and put the gown on. V9 was observed touching her face mask and the isolation bin drawer. At 2:38 PM, V9 said R418 was on isolation for C. Diff. and the staff should be wearing a mask, gown, and gloves prior to entering the room. V9 said she did not put the gloves on, and after taking the gown off, she closed the door behind her. V9 said she did not wash her hands and should have cleansed her hands by washing them with soap and water. V9 said this was done to prevent contamination of another resident or room. On June 27, 2024 at 12:05 PM, R418 had two signs showing contact isolation, and another sign showing droplet isolation. V2 (DON/Director of Nursing) said R418 had an exposure to COVID-19 and was a PUI (Person Under Investigation). On June 27, 2024 at 11 AM, V28 (IP/Infection Preventionist) said R418 was a PUI, and the staff needed to wear an N-95, gown, gloves, and a face shield to go into her room. V28 also said a resident who is tested for C. Diff. should be under contact isolation from when they are tested to when the results come back. At 2:07 PM, V28 said the droplet precaution signage indicated a regular face mask but if they are in COVID-19 isolation, it should be an N-95. At 2:16 PM, V28 showed the surveyor a sign for contact and droplet, indicating the staff should be wearing a gown, gloves, an N-95, and face shield. V28 said the contact and droplet sign should have been outside R418's room. On June 26, 2024 at 2:22 PM, V6 (CNA) said she found out yesterday that R418 was positive for C. Diff. V6 said prior to the positive results, R418 was on isolation for the urinary catheter. V6 said the signage said she needed to wear a gown and gloves when touching the urinary catheter, but she forgot to put the gown on. V6 said she was aware she should have worn all the PPE (Personal Protective Equipment) every time she went into R418's room. V6 said R418 was tested for C. Diff. On June 26, 2024 at 2:29 PM, V7 (CNA) said R418 was on contact isolation for C. Diff., and she would wear a gown, gloves, and a mask to go in. V7 said she would also wash her hands after coming out of the room because C. Diff. does not wash off using alcohol-based hand sanitizer. V7 said when R418 was on EBP, the staff were supposed to wear a gown and gloves when handling the urinary catheter. On June 26, 2024 at 2:41 PM, V8 (RN) said R418 was first on EBP for the urinary catheter and later got the call she needed to be on contact isolation for C. Diff. V8 said they should be wearing a gown and gloves if touching the urinary catheter. V8 said this was done to prevent infection to and from the patient. V8 also said the staff should be washing their hands with soap and water and using bleach to clean the surfaces. On June 27, 2024 at 2:49 PM, V2 (DON/Director of Nursing) said if a resident was on EBP, the staff should wear a gown and gloves in the room when providing patient care. V2 also said if a resident was suspected of having C. Diff., she should have been on contact isolation when the order for collection goes into the EMR (Electronic Medical Record). V2 also said for PUI's, the staff should wear an N-95 mask, gown, gloves, and a face shield. V2 said the signage should have shown contact and droplet. V2 said the staff should not touch the urinary catheter without wearing gloves for a resident in EBP for a urinary catheter and should also not place the urinary catheter bag on the ground because it was an infection control issue. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R418's face sheet showed she was admitted to the facility on [DATE] with diagnoses including urinary tract infection, generalized anxiety disorder, acute kidney failure, Stage 3 chronic kidney disease, anemia, gastroesophageal reflux disease, glaucoma, and retention of urine. R418's MDS (Minimum Data Set) was not available as R418 was a new admission. R418's progress notes were reviewed, and the following was documented: On June 23, 2024 at 10:25 PM, NP (Nurse Practitioner) ordered a stool culture for C-diff as the resident has been complaining of diarrhea. Resident is on antibiotics for UTI (Urinary Tract Infection). Stool culture orders are in for tomorrow 06/24/2023. On June 24, 2024 at 11:38 AM, 6/24 stool sample collected [rule out] CDIFF. On June 25, 2024 at 2:36 PM, Resident positive for C-Diff. [Medical Doctor]'s office (on call) message left for return call with orders. Contact isolation precaution in place. R418's POS (Physician Order Sheet) showed the following: Enhanced Barrier Precautions [related to] urinary foley catheter in place. Prevention of infection precaution. Order Date: 6/22/2024. Discontinued: 6/25/2024). Stool Culture: stool test for C-diff 06/24/2024. Order Date: 6/23/2024 Contact Precautions. Contact Isolation- Positive for C-DIFF. Order Date: 6/25/2024 The facility's Management of C. Difficile Infection (revised March 2023) showed Nurses may implement preemptive contact precautions when C. Difficile infection is suspected, pending results of testing. Once confirmed, the nurse shall obtain a physician order. Staff shall wear gloves and a gown upon entry into the resident's room and while providing care for the resident. Staff should frequently wash hands with soap and water. The facility's Coronavirus Prevention and Response policy revised March 2024 showed Empiric transmission-based precautions following close contact to be considered may include Resident is unable to be tested or wear source control as recommended for 10 days following their exposure. Resident is moderately to severely immunocompromised. Resident is residing on a unit with others who are moderately to severely immunocompromised. HCP [Health Care Professionals] who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a NIOSH-approved (National Institute for Occupational Safety and Health) particulate respirator with N95 filters or higher, gown, gloves, and eye protection. The facility's Enhanced Barrier Precautions (EBP) policy revised March 2024 showed Implementation of Enhanced Barrier Precautions - Gowns and gloves will be available upon entering resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray .High-contact resident care activities include: Dressing, Bathing, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central lines, urinary catheters, feeding tube, Wound care: any skin opening requiring a dressing . Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device is removed. 45906 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 6/25/24 at 12:02 PM, a contact precautions sign was seen on the wall outside of R43's room. R43 was not in her room and was found in the dining room sitting at a table with five other residents eating lunch. V24 (Restorative Aide) then walked up to R43 and gave her a hug and rubbed her back. Surveyor then asked V24 what R43 was in isolation for and V24 said she did not know. R43's nurse, V3 (Registered Nurse/RN) was then asked what R43 was in isolation for and V3 said ESBL (Extended Spectrum Beta-Lactamases) in the urine and R43 did not have a urinary catheter. V3 said R43 was okayed to eat in the dining room per the facility's Infection Prevention Nurse, V28. On 6/26/24 at 11:18 AM, R43 was observed in her room and contact precautions sign was still noted on the wall outside her room with PPE (Personal Protective Equipment) in a bin for staff to put in prior to going into room. The contact isolation sign reads, STOP providers and staff must clean their hands including before entering and when leaving the room. Providers and staff must also put on gloves before room entry, discard gloves before room exit, put on gown before room entry and discard gown before room exit. On 6/26/24 at 11:19 AM, V25 (Housekeeper) was seen cleaning inside R43's room wearing only gloves and mask. V25 came out of R43's room to get the broom and mop off her cart that was right outside R43's door and went back into room to sweep and mop. V25 then placed the broom and mop back on her cart and then removed her gloves. V25 then came out of R43's room and pushed her cart down the hall. V25 did not sanitize her hands or the broom and cart handles that she touched with gloves on inside R43's room. On 6/26/24 at 11:29 AM, V25 grabbed her mop off her cart with bare hands and started to mop the dining room floor. V25 then placed mop back on her cart and wheeled cart to another resident room to clean. V25 then put on a pair of gloves and entered the resident room. V25 did not sanitize her hands at any time during observation from 11:18 AM to 11:29 AM. On 6/26/24 at 11:21 AM, V26 (CNA/Certified Nurse Assistant) walked into R43's room without sanitizing her hands or putting on gown and gloves. V26 then walked out of R43's room, grabbed a water cup she had set outside R43's room on the handrail and brought that water cup into another resident's room. V26 did not perform hand hygiene. On 6/26/24 at 12:36 PM R43 was again observed eating lunch in the dining room at a table with four other residents. On 6/27/24 at 10:49 AM, a visitor was observed sitting in R43's room without any PPE on. On 6/27/24 at 10:54 AM was observed being wheeled down the hall and entering the physical therapy gym. V27 (Physical Therapy Assistant) said she knows R43 is on contact precautions, but V28 (Infection Preventionist) cleared R43 to leave her room because R43's infection is contained. R43's Face sheet shows V29 is her primary physician and she has diagnosis of urinary tract infection. R43's POS (Physician Order Sheet) shows an order dated 6/19/24 for oral antibiotic twice a day for 10 days starting on 6/20/24 to treat ESBL. R43's POS shows an order dated 6/19/24 for Contact Isolation Precautions for ESBL in the urine. R43's Care Plan last evaluated 8/31/23 shows she has urinary incontinence related to weakness, she has been diagnosed with ESBL in the urine and is receiving antibiotic therapy for urinary tract infection, and is in contact isolation precautions due to ESBL in the urine. Intervention says to inform all staff/family members/visitors of need to maintain contact precautions and wear appropriate PPE and wash hands. R43's MDS (Minimum Data Set) dated 5/14/24 shows she is frequently incontinent of urine. 3. On 6/25/24 at 12:59 PM, R23's room was observed with contact precautions sign on her door and R23 was not in her room. R23 was then observed eating lunch in the dining room sitting within 2 feet of other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/24 at 12:32 PM, R23 was again observed outside her room in the dining room around other residents. On 6/27/24 at 12:58 PM, V28 (Infection Preventionist) said she thought that as long as the ESBL in the urine is contained in an incontinence brief, that the patient was allowed to come out of their room so that is what she told the bedside nurse. V28 said R23's antibiotics are completed but R43 is still receiving antibiotics to treat the ESBL. V28 said the contact precaution order is still in place, but even when the ESBL was first diagnosed for R43 and R23, the residents were not actually in contact isolation because they could always come in and out of their rooms. V28 said staff who enter R43 and R23's rooms are expected to wear gown and gloves, so the residents are only in contact precautions inside their rooms. V28 said she did not get clearance from V29 (Primary Physician) saying that R43 could come out of her room, but she thinks that V29 told R23's nurse that it was up to the Infection Preventionist whether or not R23 could come out of her room. V28 said she does not have a policy that shows a resident on contact precautions with ESBL in the urine may come out of their room. On 6/27/24 at 2:32 PM, V2 (DON/Director of Nursing) said gown and gloves are required for contact isolation, and gown and gloves are required for a resident with ESBL in the urine. V2 said a resident with ESBL in the urine can leave their room if the urine is contained. V2 said if a resident with ESBL in the urine is incontinent of urine and wears a brief, the ESBL is not contained. V2 said if staff crosses the barrier of the doorway and enters the room of a contact precaution resident, the staff needs to wear gown and gloves because if they don't wear the proper PPE, their clothes or hands can become contaminated and they can then track that bacteria to other places in the facility. V2 said housekeeping should absolutely be wearing gown and gloves while cleaning a contact precaution room because they are the staff that are coming in most contact with all of the potentially contaminated surfaces. V2 said a housekeeper should sanitize her broom and mop handles while leaving a contact precaution room so she does not potentially contaminate other surfaces she touches and cause an outbreak. On 6/27/24 at 2:28 PM, V29 (Primary Physician) said incontinent residents who are in contact isolation for ESBL in the urine need to stay in their rooms so they don't risk spreading the infection to other residents. R23's Face sheet shows V29 is her primary physician and she has diagnosis of ESBL. R23's POS shows an order dated 6/15/24 for oral antibiotic twice a day for 10 days starting on 6/16/24 to treat ESBL in the urine. R23's POS shows an order dated 6/15/24 for contact isolation precautions due to ESBL in the urine. R23's Care Plan last evaluated on 8/15/23 shows she is in contact isolation due to ESBL in the urine with a goal to not spread to other residents or staff and intervention: inform all staff/family members/visitors of need to maintain contact isolation precautions and wear appropriate PPE. R23's MDS dated [DATE] shows she is frequently incontinent of urine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy titled, Transmission-Based (Isolation) Precautions last revised March 2024 states, Policy: It is our policy to take appropriate precautions to prevent transmission of infectious agents, based on the pathogens' modes of transmission . Policy Explanation and Compliance Guidelines: 1. Facility staff will apply Transmission-Based Precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission .3. Residents on transmission-based precautions shall remain in their rooms except for medically necessary care .7. Contact Precautions-a. intended to prevent transmission of infectious agents that are spread by direct or indirect contact with the resident or the resident's environment .c. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens .f. Contact precautions will be used for residents infected or colonized with MDROs in the following situations: i. When a resident has wounds, secretions, or excretions that are unable to be covered or contained . 41384 4. On 06/25/24 at 12: 40 PM, during dining observation, V5 (Nurse) was observed feeding R167, and then got up and went to R117's table and picked up his glass of water and glass of lemonade but did not clean her hands before touching them. V5 then left R117's table and walked over to the table were R23 was sitting and took R23's plate of food from V37 (Server), still with unclean hands, and then placed R23's plate in front of R23, then V5 returned to feeding R167. V5 never cleaned her hands when going from one resident to the next. On 06/27/24 at 1:00 PM, V2 DON (Director of Nursing) said that after feeding the resident, V5 should have cleaned her hands before grabbing R117's cups and then she should have cleaned her hands before touching R23's plate, and again clean her hands before returning to feed R167 for infection control and cross contamination reasons. 5. On 06/25/24 at 11:27 AM, V3 (Nurse) and V4 CNA (Certified Nurse's Assistant) were observed assisting R29 to the toilet and providing incontinence care for R29. V3 and V4 with gloved hands, removed R29's soiled brief and then sat her on the toilet. Then V4 with same gloved hands, picked up a package of wipes and a clean brief and handed them to V3 who was also still wearing the same pair of dirty gloves. V3 then provided incontinence care for R29. V3 and V4 then assisted R29 to a standing position and attached her clean brief, pulled up her pants, and adjusted her clothes with the same dirty gloved hands. On 06/25/24 at 11:35 AM V3 said We failed to clean our hands when we were going from dirty to clean. V3 said they should clean their hands after going from dirty to clean area to prevent an infection and cross contamination. V4 said, I thought we only change our gloves if we touch urine or feces. On 06/27/24 at 12:39 PM, V2 DON said that staff have to clean their hands and change their gloves after they are dirty before they go to a clean area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146110	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smith Crossing	10501 Emilie Lane Orland Park, IL 60467

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On 06/25/24 at 11:38 AM V3 and V4 were observed toileting and providing peri care for R44. V4 was observed with gloved hands pulling R44's pants and underpants down. V3 and V4 assisted R44 to the toilet, and after R44 was done using the toilet, V3 & V4 assisted R44 to a standing position and then V4 provided incontinence care, opened a jar of skin cream, applied the cream to R44's buttocks, then V3 and V4 pulled up R44's underpants and pants. V4 did this without removing her gloves and cleaning her hands first. On 06/25/24 at 11:50 AM, V4 said that after she provided peri care, she should have removed her gloves and cleaned her hands to prevent the spread of bacteria and cross contamination. On 06/27/24 at 12:44 PM, V2 said that the staff should have performed hand hygiene. V2 said that hand hygiene should be done after removing gloves and before putting on a new pair when going from dirty to clean. 7. On 06/26/24 at 11:43 AM, V20 (CNA) & V21 (Wound Nurse) were observed providing incontinence care and wound care for R29. V21, with gloved hands, removed R29's sock and medical boot off of R29's right foot. Then V21 applied skin prep to R29's wound on her right heel. V21 did this with the same gloved hands she started with. Then V21 and V20 pulled R29's pants down. V21 then picked up the clean drape cloth she had with the wound supplies on and placed it on R29's bed, again with her dirty gloved hands. V20 and V21 then opened R29's bowel movement soiled brief. V21 then went into the bathroom for wipes, and then put the wipes on the clean drape. V21 then went into the bathroom and got new brief still with dirty gloved hands. After V21 got the clean brief, V21 removed her gloves, cleaned her hands with hand sanitizer and then went in the hall to the medication cart to get an antifungal cream. V21 then put on clean gloves and proceeded to provide incontinence care to R29. V21 used one wipe to remove stool from R29's buttocks. V21 wiped 6 times and only folding the wipe once. Wiping the skin with the same area on the wipe. Then V21 removed her gloves and put on clean gloves but did not clean her hands before putting on the clean gloves. V21 then applied a barrier cream around the outside of R29 sacrum wound. V21 then applied collagen with silver into wound and applied a 4X4 adhesive dressing. V21 then applied antifungal ointment to R29's buttocks. V21 and V20 then put a clean brief on R29. V21 did not remove her gloves and clean her hands before putting on the clean brief. V21 continued with dirty gloved hands, pulling up R29's pants putting on R29's sock and medical boot, and adjusting R29's clothing. V21 removed the dirty gloves from her hands and then opened the door and then disposed of the garbage, V21did not clean her hands until after disposing of the garbage. On 06/26/24 at 12:08 PM, V21 said that even though she had not actually cleaned her hands after removing her gloves she felt that her hands were clean. V21 said that she was not aware that she should remove her gloves and clean her hands after providing wound and before she put a clean brief on the resident. V21 said that she should have not wiped R29's buttocks several times with the same wipe. V21 said that she should have cleaned her hands after she took off her gloves and before she put on clean gloves when going from dirty to clean to avoid cross contamination and for infection control practices. 06/27/24 01:16 PM V2 (DON) said that the nurse should have cleaned her hands after going from a dirty area and before going to a clean area, and after removing her gloves and before putting on new gloves for infection control and cross contamination reasons. 8. On 06/26/24 at 12:34 PM while V30 (Nurse) was providing care to R45 in his room, a dirty sheet and blanket were observed on the floor in R45's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/27/24 at 01:28 PM V2 (DON) said that the dirty linen should not be on the floor because R45 is on EBP (enhanced barrier precautions) for his G-tube and what is on the linen, is now on the floor. V2 said the dirty linen should not be on the floor because of infection control and the bacteria that is on the linen, is now on the floor and from the floor to whoever steps on the floor and tracks it to wherever they are going. The facility's Handling Soiled Linen policy with the reviewed/revised date of March 2024 showed, the purpose of this procedure is to provide guidelines for the proper handling of soiled linen to prevent the transfer of microorganisms to residents and employees. The policy showed that soiled linen/contaminated laundry should not be allowed to touch the uniform or floor. The facility's Hand Hygiene policy dated March 2024 showed, all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. The facility's Clean Dressing Change policy dated March 2024 under # 9. loosen tape and remove dressing, 10. remove gloves, 11. sanitize hands and put on clean gloves, 12. clean wounds as ordered, 14. sanitize hands and put on clean gloves, and 15. apply meds as ordered. The facility's Policy Infection control March 2024 showed all staff engaged in direct patient care shall be instructed in correct techniques and be familiar with the facility's established infection control policies and procedures. 5. hand hygiene protocol: all staff shall wash their hands when coming on duty, between patient contacts after handling contaminated objects, after PPE removal, and before going off duty. For routine patient care, staff shall wash their hands with soap and water or a waterless alcohol agent before and after patient care.