STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155835	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Crown Point LLC	1555 S Main Street Crown Point, IN 46307

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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. 45666 Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and an assessment to self-administer their own medications for 1 of 1 resident reviewed for self-administration of medication. (Resident 40) Finding includes: During a random observation on 1/6/25 at 10:52 a.m., there was a medication tablet in a clear medication cup on Resident 40's bedside table. At the time, Resident 40 indicated the medication was an extra strength Tylenol and the nurse always left her medications at the bedside for her to take before she went to therapy. Resident 40's record was reviewed on 1/7/25 at 3:07 p.m. Diagnoses included, but were not limited to, acute kidney failure, pressure ulcer of the sacral region, and acute respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 12/31/24, indicated the resident was cognitively intact for daily decision making. A Care Plan, revised on 1/6/25, indicated the resident had an order for self-administration of all medications and may keep at bedside. An intervention, dated 10/3/24, indicated to assess resident's ability to safely self-administer medications specified on admission/re-admission, quarterly, with change in medication orders, and with significant changes in condition. A Physician's Order, dated 12/30/24, indicated acetaminophen (Tylenol) oral tablet 500 milligram, give 2 tablets by mouth every 6 hours as needed for pain. There were no self-administration assessments or physician's orders for the self-administration of Tylenol. During an interview on 1/6/25 at 11:42 a.m., LPN 2 indicated she had left Resident 40's medications at the bedside during the morning medication pass as the resident was allowed to self-administer all medications. During a follow up interview on 1/6/25 at 2:22 p.m., LPN 2 indicated the most recent self-administration of medications assessment did not have all of the resident's medications listed and she did not have an order to self-administer all medications. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/6/25 at 2:44 p.m., the Director of Nursing indicated the order for self-administration of all medications must have been dropped off when she had gone out to the hospital. A policy titled, Self Administration of Medications and Treatments indicated .1. Self administration of medications and treatments is determined by physician order after determining that the resident is able to self administer .Procedure 1. If it is determined by a member of the interdisciplinary team, or if the resident requests to self administer, it is documented in the chart and the physician is called for an order to self administer medications, and keep the medications at the bedside. 2. Assessment of the ability to self-administer medications will be done by nursing using the tool Assessment for Self-Administration of Medications .7. A care plan is made for the resident who self administers medications, and documentation should be present in the nursing notes of teaching related to self administration of the medications or treatments. 3.1-11(a)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 45666 Based on record review and interview, the facility failed to ensure a resident and/or their Responsible Party were notified in writing related to a transfer to the hospital for 1 of 4 residents reviewed for hospitalization . (Resident 40) Finding includes: Resident 40's record was reviewed on 1/7/25 at 3:07 p.m. Diagnoses included, but were not limited to, acute kidney failure, pressure ulcer of the sacral region, and acute respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 12/31/24, indicated the resident was cognitively intact for daily decision making. A Progress Note, dated 12/21/2024 at 7:39 a.m., indicated the resident was asleep in bed with the head of bed elevated. The resident was observed to have tremors. The resident woke up when stimulated. She was using accessory muscles while breathing, lips slightly blue, and having difficulty breathing while speaking. The resident denied shortness of breath when asked. Oxygen was applied via nasal cannula and she was sent to the hospital for a medical evaluation via 911. The resident left awake, alert and oriented, verbally responsive, and with a rebreather mask. The resident left on a stretcher accompanied via 2 attendants. The physician, emergency contact, and supervisor were made aware. There was no documentation to indicate the State approved transfer form was completed and sent with the resident. During an interview on 1/10/25 at 10:57 a.m., the Director of Nursing indicated the resident signed/received a bed hold policy and transfer form at the time of admission. An updated form was not provided. During an interview on 1/13/25 at 12:11 p.m., the Administrator indicated all resident's received a bed hold and transfer form at the time of admission and the facility did not send it out each time of transfer from the facility. A policy titled, Discharges indicated .Hospital Transfer .4. Inform the resident and resident's responsible party of the transfer. 5. Prepare transfer form with a face sheet and medication list . 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii)

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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. 45666 Based on record review and interview, the facility failed to ensure a resident and/or their Responsible Party were sent the facility's bed-hold and reserve bed payment policy before and upon transfer to the hospital for 1 of 4 residents reviewed for hospitalization . (Resident 40) Finding includes: Resident 40's record was reviewed on 1/7/25 at 3:07 p.m. Diagnoses included, but were not limited to, acute kidney failure, pressure ulcer of the sacral region, and acute respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 12/31/24, indicated the resident was cognitively intact for daily decision making. A Progress Note, dated 12/21/2024 at 7:39 a.m., indicated the resident was asleep in bed with the head of bed elevated. The resident was observed to have tremors. The resident woke up when stimulated. She was using accessory muscles while breathing, lips slightly blue, and having difficulty breathing while speaking. The resident denied shortness of breath when asked. Oxygen was applied via nasal cannula and she was sent to the hospital for a medical evaluation via 911. The resident left awake, alert and oriented, verbally responsive, and with a rebreather mask. The resident left on a stretcher accompanied via 2 attendants. The physician, emergency contact, and supervisor were made aware. There was no documentation to indicate the facility's bed-hold policy was sent to the resident and/or their Responsible Party. During an interview on 1/10/25 at 10:57 a.m., the Director of Nursing indicated the resident signed/received a bed hold policy and transfer form at the time of admission. An updated form was not provided. During an interview on 1/13/25 at 12:11 p.m., the Administrator indicated all residents received a bed hold and transfer form at the time of admission and the facility did not send it out each time of transfer from the facility. 3.1-12(a)(25)(A)

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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** 32582 Based on observation, record review, and interview, the facility failed to ensure a resident received medications as ordered for 1 of 1 resident reviewed for dialysis, failed to hold medications outside of ordered parameters for 1 of 1 resident reviewed for discharge, failed to assess and monitor an abdominal hernia, and lack of treatment in place for leg swelling for 1 of 3 residents reviewed for edema and skin conditions. (Residents C, B, and D) Findings include: 1. Resident C's record was reviewed on 1/7/25 at 2:08 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, dependence on renal dialysis, unspecified dementia, and gastrostomy. The Admission Minimum Data Set (MDS) assessment, dated 1/2/25, indicated the resident had severe cognitive impairment, received renal dialysis and tube feedings. The resident went to renal dialysis on Monday, Wednesday and Friday mornings. The resident went to dialysis on 1/2/25 and 1/3/25 due to the holiday on Wednesday,1/1/25, that week. The January 2025 Medication Administration Record (MAR) indicated the resident did not receive his morning medications on 1/2/25, 1/3/25 and 1/8/25 because he was out of the facility. The MAR was left blank on the morning of 1/6/25. The medications that were not given included, but were not limited to, doxycycline (an antibiotic), carvedilol (hypertension medication), and eopetin alfa injection (for anemia). During an interview on 1/8/25 at 2:25 p.m. with the C Unit Manager, she indicated if medications were scheduled during dialysis time, they should be rescheduled. The resident's missed medications were concerning and she would have them rescheduled. 45666 2. Resident B's record was reviewed on 1/8/25 at 9:37 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, high blood pressure, and chronic kidney disease. The Discharge Minimum Data Set assessment, dated 12/16/24, indicated the resident was cognitively intact for daily decision making. The December 2024 Physician's Order Summary indicated hydralazine oral tablet 50 milligrams, 1 tablet every 8 hours, and hold for systolic blood pressure less than 130. The December 2024 Medication Administration Record indicated the resident received hydralazine on the following dates and times with a blood pressure less than 130: - 12/7/24 at 2:30 p.m. with a blood pressure of 127/74 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 12/14/24 at 10:00 p.m. with a blood pressure of 117/59 - 12/15/24 at 6:00 a.m. with a blood pressure of 120/60 - 12/16/24 at 6:00 a.m. with a blood pressure of 128/66 During an interview on 1/10/25 at 12:40 p.m., the Nurse Consultant had no further information to provide. 3. During an observation and interview on 1/7/25 at 9:35 a.m., Resident D indicated she had a large hernia that was causing discomfort and she was having a hard time eating because of it. She had a brace that she wore before in the hospital to help with the pain that she had while coughing. The resident also indicated she had edema to both of her lower legs and was supposed to have some type of wrap to them, however the facility staff were not doing that daily. The resident's legs were observed elevated on a pillow and there was a bandage on the left lower leg. There were no wraps on either leg and her legs were swollen. During an observation on 1/8/25 at 10:47 a.m., Resident D indicated her legs had no wraps on them at the time and they had never wrapped them the previous day. Her legs were elevated on a pillow. Resident D's record was reviewed on 1/8/25 at 11:55 a.m. She readmitted to the facility on [DATE]. Diagnosis included, but were not limited to, lymphedema and heart failure. The Discharge Minimum Data Set (MDS) assessment, dated 4/15/24, indicated the resident was cognitively intact for daily decision making. The Admission Minimum Data Set (MDS) assessment, dated 1/9/25, was still in progress. The January 2025 Physician's Order Summary indicated to off load heels as tolerated every shift and give furosemide tablet (diuretic medication) 40 milligrams twice daily for fluid retention. The current Care Plan indicated the resident was at risk for alteration in skin integrity related to incontinence, head of bed elevation, and history of heart failure, lymphedema, osteoarthritis, diabetes mellitus, gastroesophageal reflux disease, and high blood pressure. Interventions included, but were not limited to, ensure the heels are elevated while in bed and monitor skin when providing cares. A Nurses' Note, dated 1/2/25 at 5:43 p.m., indicated the resident arrived to the facility and was alert and oriented and able to answer questions appropriately. She had 4+ pitting edema to the bilateral lower extremities, which were both wrapped at the time for her lymphedema. Her abdomen was soft and nontender with active bowel sounds. A Skin/Wound Note, dated 1/3/25 at 1:03 p.m., indicated the resident was admitted to the facility for therapy services. She had lymphedema to bilateral lower extremities. Ammonium lactate was ordered and applied. She had a history of lymphedema and a diagphramatic hernia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician Progress Note, dated 1/3/25 at 8:05 p.m., indicated the resident was observed in bed. She had bilateral lower extremities noted with chronic lymphedema and wrapped in ace wraps. She was on diuretic medication for the edema. The record lacked a care plan related to an abdominal hernia, an assessment or monitoring in place for the abdominal hernia, and orders for ace wraps to the bilateral lower extremities. During an interview on 1/9/25 at 2:05 p.m., the A Unit Manager indicated there was now an order for ace wraps for the bilateral lower extremities. The resident had a hernia that was inoperable. She was sent to the surgeon during a previous stay at the facility. The A Unit Manager was unable to locate an assessment for the hernia. During an interview on 1/9/25 at 2:15 p.m., the Director of Nursing (DON) indicated the staff would not document on the hernia unless she was having pain or telling staff she was having problems with it. The DON did not provide any further documentation regarding the hernia. During a follow up interview on 1/10/25 at 11:04 a.m., the DON provided documentation that the resident's hernia was addressed during her last stay in April and her Physician could not do any surgery for it. She was unable to provide an assessment of the hernia. She indicated the resident was currently on diuretics for edema, and wraps were now being added to the care plan. This citation relates to Complaint IN00449507. 3.1-37(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32664 Based on observation, interview, and record review, the facility failed to ensure an indwelling Foley (urinary) catheter collection bag for a resident with a history of infection was kept off the floor for 1 of 1 resident reviewed for urinary catheters. (Resident 160) Finding includes: On 1/7/25 at 1:40 p.m., Resident 160 was observed sitting in a wheelchair at the nurses' station. The resident was talking on the phone and her catheter collection bag was lying on the floor underneath her wheelchair. On 1/9/24 at 9:16 a.m., Resident 160 was observed sitting in a recliner in her room. The resident's catheter collection bag was touching the floor in front of the recliner. During an interview on 1/19/24 at 9:19 a.m., the A Unit Manager indicated staff should have put the resident's catheter bag into a bath basin so it would not be touching the floor. Record review for Resident 160 was completed on 1/9/24 at 9:36 a.m. Diagnoses included, but were not limited to, anxiety, cerebral palsy, chronic kidney disease, hypertension, and urinary tract infection (UTI). The resident was admitted to the facility on [DATE]. A Care Plan, dated 1/6/25, indicated the resident had a urinary catheter. An intervention included to monitor and report signs or symptoms of a UTI. The January 2025 Physician's Order Summary indicated an order for Firvanq (antibiotic) 50 mg (milligrams)/ml (milliliters) solution. Give 2.5 ml by mouth one time a day for Sepsis (serious condition in which the body responds improperly to an infection). A facility policy titled, Perineal Care, and received as current from the Director of Nursing on 1/9/25, indicated, .7. Ensure Foley catheter is positioned correctly and secured . 3.1-41(a)(2)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32664 Based on record review, observation, and interview, the facility failed to ensure timely follow up on dietary recommendations for a resident with a feeding tube was completed for 1 of 3 residents reviewed for nutrition. (Resident 46) Finding includes: Record review for Resident 46 was completed on 1/9/25 at 11:45 a.m. Diagnoses included, but were not limited to, stroke, hypertension, and intellectual disabilities. The resident was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS) assessment, dated 12/19/24, indicated the resident was moderately cognitively impaired. The resident had a feeding tube. A Care Plan, dated 12/12/24 and revised 1/6/25, indicated the resident had the potential for alteration in nutrition and hydration related to a feeding tube. An intervention included the Registered Dietician was to evaluate and make diet change recommendations when necessary. A Registered Dietician (RD) note, dated 1/7/25 at 3:52 p.m., indicated the resident's weight was slowly increasing and staff were reporting a fair intake at most meals. A recommendation was made to place the tube feedings on hold and add supplements by mouth to ensure adequate intake. Add Med Pass (nutritional supplement drink) 120 ml (milliliters) every 6 hours and give a Magic Cup (fortified nutrition dessert cup) with all meals. A Nurse Practitioner's (NP) note, dated 1/8/25 at 2:18 p.m., indicated the resident received bolus feedings every 6 hours when the resident did not eat more than 50%. The January 2025 Physician's Order Summary indicated orders for the following: - regular diet with mechanical soft texture; give feeding when the resident ate less than 50% of their meal - after meals bolus (way to send formula through a feeding tube using a syringe), feed Jevity (fortified therapeutic nutrition) 1.2. Hold the feeding if the resident ate more than 50% of each meal. There was a lack of documentation to indicate the NP was notified of the RD's recommendations of the Med Pass and Magic Cup. There were no progress notes or Physician's Orders indicating the recommendations were addressed. There were no physician's orders for the Med Pass or the Magic Cup. On 1/10/25 at 12:31 p.m., resident was sitting in a wheelchair in her room. The resident was brought her lunch tray. There was no Magic Cup observed on the tray. The resident's meal ticket did not have a Magic Cup listed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/10/25 at 2:16 p.m., the A Unit Manager indicated the nursing staff was responsible to follow up with the RD's recommendations. She was unsure about the RD's recommendations for the resident and she would have to check on it. During an interview on 1/10/25 at 3:08 p.m., the A Unit Manager indicated she received the RD's recommendations on 1/8/25 and sent them to the Physician's office. The NP saw the resident on 1/8/25, but she was unsure if that was before or after she sent the recommendations to the office. She did not address the recommendations in person with the NP that day or after and the office had not responded to her about the recommendation. The A Unit Manager followed back up on the recommendation with the Physician's office on 1/10/25, and they put an order in for the Med Pass and Magic Cup. She indicated she had not followed back up on the recommendations until it was brought to her attention. A facility policy titled, Dietary Referrals and received as current from the Director of Nursing on 1/10/25, indicated, .1. If there is a referral from dietician consult, the nurse is to inform the physician of the recommendation .3. Documentation will be present in resident records . 3.1-46(a)(1) 3.1-46(a)(2)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582 Based on observation, record review, and interview, the facility failed to ensure a resident with a gastrostomy (surgical insertion of a feeding tube) received the appropriate treatment related to incorrect flow rate for the tube feeding for 1 of 1 resident reviewed for tube feedings. (Resident C) Finding includes: On 1/8/25 at 2:20 p.m., Resident C was observed lying in his bed. His tube feeding was on and flowing at 75 milliliters per hour (ml/hr). On 1/9/25 at 9:18 a.m. and 11:20 a.m., the resident was in bed and his tube feeding was on and flowing at 45 ml/hr. The resident's record was reviewed on 1/7/25 at 2:08 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, dependence on renal dialysis, unspecified dementia and gastrostomy. The Admission Minimum Data Set (MDS) assessment, dated 1/2/25, indicated the resident had severe cognitive impairment, received renal dialysis, and tube feedings. A Physician's Order, dated 1/7/25, indicated the resident was to receive Nepro with Carb Steady via tube feeding at 65 ml/hr for 24 hours daily. During an interview on 1/9/25 at 11:20 a.m., the C Unit Manager indicated the tube feeding should be 65 ml/hr and she would correct it. 3.1-44(a)(2)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582 Based on observation, record review, and interview, the facility failed to ensure a peripheral inserted central catheter (PICC) was maintained related to the dressing not being changed as ordered for 1 of 3 residents reviewed for non-pressure skin conditions. (Resident 116) Finding includes: On 1/6/25 at 1:37 p.m., Resident 116 was observed in his bed. He had a PICC inserted in his right upper arm with a dressing dated 12/23/24. The resident's record was reviewed on 1/6/25 at 3:00 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to unspecified dementia, asthma, and gout. The Admission Minimum Data Set (MDS) assessment, dated 12/30/24, indicated the resident had moderate cognitive impairment, was dependent on staff for transfers, and did not have IV access. A Physician's Order, dated 12/25/24, indicated to change the PICC dressing every seven days on Saturday. The January 2025 Medication Administration Record indicated the dressing had been changed on 1/4/25. During an interview with RN 4 on 1/6/25 at 1:51 p.m., she indicated the dressing was dated 12/23/24 and had not been changed since admission. 3.1-47(a)(2)

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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. 32582 Based on observation, record review, and interview, the facility failed to ensure infection control measures were in place and maintained related to improper protective personal equipment (PPE) worn in an isolation room for 1 of 1 resident reviewed for respiratory care. (Resident 125) Finding includes: On 1/7/25 at 10:35 a.m., Resident 125 was observed in her room. There were isolation signs on the resident's door that indicated she was on contact and droplet precautions. Another sign indicated the room was a Red Zone, and PPE required to enter was an N95 or approved KN95 respiratory mask, goggles or a faceshield, gown and gloves. There was a PPE bin outside the resident's room. On 1/8/25 at 9:32 a.m., LPN 1 was observed in the resident's room speaking with a family member. The nurse had her personal glasses on and was wearing a surgical mask. She was not wearing an N95 mask, goggles or a faceshield, gown or gloves. LPN 1 exited the room at 9:40 a.m. During an interview at that time, the LPN indicated the resident was on isolation because she was immunocompromised, she was not aware the resident had coronovirus. Resident 125's record was reviewed on 1/10/25 at 9:00 a.m. Diagnoses included, but were not limited to, heart failure, acute and chronic respiratory failure, and hypothyroidism. The Admission Minimum Data Set assessment, dated 1/1/25, indicated the resident was cognitively intact, required supervision for transfers, toileting and bed mobility, and used oxygen. A Medication Administration Note, dated 1/1/25, indicated the resident had a persistent cough and chronic obstructive pulmonary disease and the on call Physician had ordered a respiratory panel (test for respiratory pathogens) to be done. A Health Status Note, dated 1/3/25, indicated the resident had tested positive for coronovirus and would be placed on strict droplet isolation. A Physician's Order, dated 1/4/25, indicated strict transmission based contact/droplet isolation precautions and all services to be provided in private room. A Physician Progress Note, dated 1/8/25, indicated the resident had tested negative for COVID-19. However the respiratory panel detected Coronovirus OC 43, .while this is not COVID-19, COVID-19 and this virus are both coronoviruses, and are transmitted via respiratory excretion. For this reason, the patient was kept in isolation for 10 days to avoid the risk of spreading this virus to staff and patients. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155835	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Crown Point LLC	1555 S Main Street Crown Point, IN 46307

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The document, Infection Control Policy, reviewed 11/2024, indicated, .Droplet Precautions will be used for residents known or suspected to be infected with microorganisms transmitted by droplets that can be generated by the resident during coughing, sneezing, talking or during cough-inducing procedures .don a mask prior to entering the room . and, .Contact Precautions will be used for specified resident known or suspected to be infected with microorganisms that can be transmitted by direct contact .or indirect contact (touching) with environmental surfaces or resident care items in the resident's environment . [NAME] gloves and gown when entering the room. 3.1-18(a)(2)