STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165174	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa DE Paz Health Care Center	2121 West 19th Street Sioux City, IA 51103

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48004 Based on clinical record review, resident grievances, resident interview, staff interview, and policy review the facility failed to ensure 3 of 3 residents ' personal property was protected from loss or theft (Resident #12, #39, #51) . The facility reported a census of 66 residents. Findings include: 1. Review of Resident #12's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS further revealed an admitted [DATE] to the facility from a short term hospital stay. Interview on 3/31/25 at 11:02 AM with Resident #12 revealed she had missing clothing. Resident #12 further revealed she was missing shorts, and pants. Resident #12 stated she had told staff, but did not file a grievance. Review of facility provided inventory list with Resident #12's name and date of 2/27/25 revealed no shorts on the list and 10 pairs of pants. 2. Review of Resident #39's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. The MDS further revealed an admitted [DATE] into the facility. Interview on 3/31/25 at 1:01 PM with Resident #39 revealed that he has several items missing, and has turned it into the management here at the facility. Resident #39 stated he was missing a hawkeye shirt, socks, underwear, 7 pairs of pants, and an electric razor. Resident #39 then revealed that after 3 weeks of being here the facility finally decided to do an inventory sheet after his items were starting to go missing. Resident #39 revealed he wants his items replaced as he does not have the money to keep buying new stuff. Review of a facility provided inventory list dated 12/26/24 with Resident #39's name revealed Resident #39 had 4 t-shirts (No description), 3 pairs of socks were marked, 6 pairs of underwear, 5 pairs of pants, and 3 pairs of shorts. No electric razor was listed on the inventory sheet. Review of a facility provided grievance form dated 12/2024 revealed Resident #39 filed a grievance 12/13/24 for a missing electric razor as well as missing laundry on 12/30/24. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #51's MDS dated [DATE] revealed a BIMS score of 13 indicating intact cognition. The MDS further revealed an admitted [DATE] into the facility. Interview on 3/31/25 at 11:23 AM with Resident #51 revealed that she is missing a couple bras. Resident #51 revealed that she has told staff and it has not been replaced. Resident #51 further revealed no grievance has been filed. Review of a facility provided inventory list for Resident #51 with a date of 2/6/24 revealed no bras were marked on the inventory list. Interview on 4/02/25 at 9:43 AM with Staff B Social Services revealed she will give an inventory sheet to new admits and 2nd shift usually helps with filling them out. Staff B then revealed she will ask residents and staff to complete the inventory sheets as soon as possible. Staff B stated the nurses are to update the inventory list in the file. Staff B stated if a resident states something is missing an investigation would be completed. Staff B proceeded that per the facility policy the facility does not replace lost or stolen items. Interview on 4/02/25 at 10:12 AM with the Administrator revealed her expectation would be for inventory lists to be updated, filled out correctly, detailed inventory upon admit, and updated as items come in. Review of a facility provided policy titled, Personal Property with a revision date of August 2022 revealed: a. The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review and staff interview, the facility failed to refer 1 resident with a negative Level I result for the PreAdmission Screening and Resident Review (PASRR), who was later identified with newly evident or possible serious mental disorder, intellectual disability, or other related condition, to the appropriate state-designated authority for Level II PASRR evaluation and determination for 1 out of 6 residents (Resident #60) reviewed for PASRR requirements. The facility reported a census of 66 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #60 documented diagnoses psychotic disorder, aphasia and diabetes mellitus. The MDS included a Brief Interview for Mental Status (BIMS) score that was not completed. The MDS revealed diagnosis of psychotic disorder. Review of the active diagnosis list in the clinical record revealed the following diagnosis of delusional disorder. The Care Plan with revision date of 3/7/25 revealed the resident takes psychotropic medications. Review of the PASRR dated 3/29/24 revealed the resident had no mental health diagnosis. The clinical record lacked an updated PASRR to include the delusional disorders. Review of the facility provided policy Behavioral Assessment, Intervention and Monitoring revised March 2019 revealed new onset or changes in behavior that indicate newly evident or possible serious mental disorder, intellectual disability, or a related disorder will be referred for a PASARR Level II evaluation. Interview on 4/2/25 at 10:52 a.m., with the Social Services Director revealed if a resident's diagnosis is not one the admission PASRR then she would have resubmitted the PASRR. The PASRR should have been resubmitted with the delusional disorder diagnosis listed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review and staff interview the facility failed to revise and update care plans to include and address high risk medications and side effects to watch and failed to include enhanced barrier precautions for 3 out of 20 sampled residents reviewed for comprehensive care plans (Resident #39, #48 and #66). The facility reported a census of 66 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #48 documented diagnoses of depression, non-Alzheimer's Dementia and acute respiratory failure. The MDS showed the Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. Review of Resident #20's March Medication Administration Record revealed the following orders: a. Fluoxetine (antidepressant medication) daily with a start date of 10/6/24 b. Olanzapine (antipsychotic medication) daily with a start date of 3/20/24 c. Morphine (narcotic medication) as needed with a start date of 3/18/25 Review of the Care Plan with a revision date of 3/14/25 lacked non pharmacological interventions for the antidepressant and antipsychotic medications. The care plan lacked information regarding the usage of narcotic pain medication as well as side effects to watch for with narcotic medication usage and non pharmacological interventions to use prior to medication usage. 2. The MDS assessment dated [DATE] for Resident #66 documented diagnoses of hypertension, hyperlipidemia and non-Alzheimer's dementia. The MDS showed the Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. Review of Resident #20's March Medication Administration Record revealed the following orders: a. Rexulti (antipsychotic medication) daily b. Alprazolam tablet (anti-anxiety medication)12 hours as needed Review of the Care Plan with a revision date of 3/15/25 lacked information on the usage of antipsychotic and anti-anxiety medication usage, side effects to watch for and non-pharmacological interventions to use prior to as needed medications. Interview on 4/02/25 at 10:33 a.m., with the Director of Nursing (DON) revealed the care plan should have had high risk medications and side effects on them. The DON further revealed the facility does not usally include narcotic medications on the care plan. 48004 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #39's MDS dated [DATE] revealed an admitted to the facility of 11/29/24. Review of Resident #39's Electronic Healthcare Record (EHR) page titled Physicians Orders revealed an order for Capecitabine oral tablet 500mg give 4 tablets by mouth 2 times a day for chemotherapy related to malignant neoplasm of the rectum. Observation on 3/31/25 at 1:00 PM revealed a sign by Resident #39's door stating that Resident #39 was on contact and droplet precautions. Review of Resident #39's Care Plan with a revision date of 3/18/25 revealed no documentation of contact precautions, or droplet precautions. Interview on 4/02/25 at 8:53 AM with the Director of Nursing (DON) revealed she would expect care plans to include documentation of contact and droplet precautions. Review of a facility provided policy titled, Care Plans, Comprehensive Person-Centered with a revision date of March 2022 revealed: a. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' conditions change.

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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** 44420 Based on clinical record review, observation, resident interview and staff interviews, the facility failed to prevent accidents and hazards by not properly using a motion detector to prevent a fall that caused the need for an emergency room (ER) visit, facial bruising, laceration to the forehead and the need for pain medication for 1 of 3 residents reviewed (Resident #3). The facility also failed to use adequate transfer techniques while using a mechanical lift for 2 of 3 residents observed (Resident #8 and #44). The facility reported a census of 66 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 documented diagnoses of heart failure, respiratory failure and osteoarthritis. The MDS showed the Brief Interview for Mental Status (BIMS) score of 02, which indicated severe cognitive impairment The MDS also showed Resident #3 dependent for toileting hygiene and baths.The resident also required substantial assistance for transfers. Observation on 3/31/25 at 12:20 PM showed Resident #3 with fading dark purple bruising to the right side of forehead, temple, check, jawline and neck. The Care Plan for Resident #3 identified the resident at risk of falling related to confusion, gait/balance problems, poor communication/comprehension and unaware of safety needs. On 3/8/25 the post fall intervention included a motion alarm initiated to sound a silent alarm when the resident tried to self transfer/walk without staff assistance. The Fall Risk assessment dated [DATE] for Resident #3 identified the resident to be a high fall risk. The Incident Report dated 3/17/25 at 9:15 AM for Resident #3 documented: When CNA entered the resident ' s room to answer the call light resident was lying face down on the floor mat in front of her chair with her face on the tile floor, and the resident was bleeding from her forehead, CNA yelled out for assistance stating that the resident had fallen and was bleeding. When this nurse entered the resident room, the resident was lying on her stomach on the floor mat and the resident was face down on the tile bleeding from her forehead. The call light was still clipped to the resident's shirt, she was wearing slippers on her feet, her motion sensor was turned on but not facing the resident, her arms were under her chest supporting her upper body and her legs were straight out. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 3/17/25 at 7:33 PM for Resident #3 documented the following: When CNA entered the resident ' s room to answer the call light resident was lying face down on the floor mat in front of her chair with her face on the tile floor, and the resident was bleeding from her forehead, CNA yelled out for assistance stating that the resident had fallen and was bleeding. When this nurse entered the resident room, the resident was lying on her stomach on the floor mat and the resident was face down on the tile bleeding from her forehead. The call light was still clipped to the resident's shirt, she was wearing slippers on her feet, her motion sensor was turned on but not facing the resident, her arms were under her chest supporting her upper body and her legs were straight out. With the Certified Nursing Assistant (CNA) translation resident stated, I was trying to walk to the bathroom when I lost my balance and fell . Pressure applied to residents forehead to stop the bleeding while lying next to resident to keep her stable and trying to keep her from moving around in case of neck or back injury obtained, unable to get original set of vitals due to the position of the resident, the Assistant Director of Nursing (ADON) phoned 911 for ambulance and spoke the provider ' s Registered Nurse (RN) to get orders to send to ER for evaluation, order to transport obtained, message left for family to return telephone call to the facility as soon as possible, ambulance arrived at 9:45 PM and transported resident to the ER. ER phoned with a report. The resident received sutures and computed tomography (CT) scans while in ER and returned to the facility at 3:30 PM. The neurological assessment was performed upon return and multiple messages left for the family to call the facility. The emergency room notes dated 3/17/25 at 1:09 PM for Resident #3 documented: This is a [AGE] year old female who presents here today with complaints of fall. She has a past medical history of hypertension, hyperlipidemia diabetes, gastroesophageal reflux disease, depression and thyroid disease. History was provided by the patient. She was hypertensive, remaining vital signs were stable while in the ER. The physician exam was significant for a two centimeter laceration on the right side of forehead with surrounding abrasion. My differential diagnosis included fall, head injury, laceration, contusion, skull fracture and intracerebral hemorrhage. I therefore ordered a head CT. I independently interpreted the imaging which showed no acute findings. The Progress Note dated 3/17/2025 at 9:40 PM for Resident #3 identified a bandage present on the resident's face that remained intact. The resident complained of mild pain and a standing order initiated for Acetaminophen. The Progress Note dated 3/20/2025 at 5:33 AM identified Resident #3 given tylenol (Acetaminophen) for headache; relief provided. The March 2025 Medication Administration Record (MAR) revealed Resident #3 received Acetaminophen 650 milligrams as follows: March 17th at 7:31 PM, March 19th at 2:16 PM and March 20th at 1:30 AM and 4:08 PM. The Weekly Skin assessment dated [DATE] at 2:12 PM for Resident #3 identified scattered bruising to bilateral upper and lower extremities and the face. Staff inaccurately documented the laceration with sutures to the right side of the forehead as a surgical incision. The Weekly Skin assessment dated [DATE] at 3:53 PM for Resident #3 identified scattered bruising to bilateral upper and lower extremities and the face. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/2/25 at 12:07 PM, Staff E, Licensed Practical Nurse (LPN) reported a CNA found Resident #3 on the floor. When Staff E entered the room she noted Resident #3 to be face down with her body on a floor mattress pad and face against the floor tile. Staff E reported she held a towel to the resident's forehead to control bleeding. Staff E reported to prevent further injury she kept the resident in the same position until emergency personnel could arrive. Staff E did not visualize the resident's facial injuries. Staff E recalled the resident to be wearing slippers, with the call light string clipped to clothing. Staff E reported the facility started using a silent motion alarm about two weeks prior to the fall. Staff E stated, the motion alarm was effective. It went off at the nurse's station when the resident moved. Everyone could hear it. Staff E reported no falls had occurred since initiating the motion alarm. Staff E stated, the alarm didn't go off when the resident fell When I checked the alarm it was not pointed at the resident. Staff E denied knowledge of how or why the motion alarm was moved. The Falls - Clinical Protocol dated 2021 indicated: Assessment and Recognition 1. The physician will help identify individuals with a history of falls and risk factors for falling. Staff will ask the resident and the caregiver or family about a history of falling. The staff and physician will document in the medical record a history of one or more recent falls (for example, within 90 days). While many falls are isolated individual incidents, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause. 2. In addition, the nurse shall assess and document/report the following: Vital signs; Recent injury, especially fracture or head injury; Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.;Change in cognition or level of consciousness; Neurological status: Pain; Frequency and number of falls since last physician visit; Precipitating factors, details on how fall occurred; All current medications, especially those associated with dizziness or lethargy: and All active diagnoses. 3.The staff and practitioner will review each resident's risk factors for falling and document in the medical record. Examples of risk factors for falling include lightheadedness or dizziness, multiple medications, musculoskeletal abnormalities, peripheral neuropathy, gait and balance disorders, cognitive impairment, weakness, environmental hazards, confusion, visual impairment, hypotension, and medical conditions affecting the central nervous system. After a first fall, the staff (and physician, if possible) should watch the individual rise from a chair without using his or her arms, walk several paces, and retum to sitting. If the individual has no difficulty or unsteadiness, additional evaluation may not be needed. If the individual has difficulty ar is unsteady in performing this test, additional evaluation should occur. 4.The physician will identify medical conditions affecting fall risk (fur example, a revent stroke ar medications that cause dizziness or hypotension) and the risk for significant complications of falls (for crumple, increased fracture risk in someone with osteoporosis or increased risk of bleeding in someone taking an anticoagulant). Falls often have medical causes; they une not just a nursing issue. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. Frail elderly individuals are often at greater risk for serious adverse consequences of falls.Risks of serious adverse consequences can sometimes be minimixed even if falls cannot be prevented. 3. If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed; for example, if the problem that required the intervention has been resolved by addressing the underlying cause. 4. If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident falling (instead of, or in addition to those that have already been identified) and also reconsider the current interventions. 5. As needed, and after an appropriately thorough review, the physician will document any uncorrectable risk factors and underlying causes In an interview on 4/3/25 at 8:40 AM, the Administrator reviewed the Progress Notes and Care Plan then compared the dates with the purchase order of the motion alarm. The Administrator reported that she wanted to make certain staff did not document the use of the motion alarm as a fall intervention if the alarm was not yet available The Administrator confirmed the motion alarm to be present at the facility at the time of the fall. The Administrator stated, it would 've been a whole other problem if they were documenting an intervention they couldn't have been using. The Administrator acknowledged to prevent a fall the motion alarm needed to be pointed at the resident to alert staff of the resident's movement. 2. Observation on 4/2/25 at 8:38 AM revealed Staff C, CNA, and Staff D, CNA transferred Resident #8 from the wheelchair to the bed using a mechanical lift. When Staff C raised the resident out of the wheelchair using the mechanical lift, she failed to leave the wheels of the lift un-braked. When Staff C then lowered the resident into bed using the mechanical lift, she failed to leave the wheels of the lift un-braked. 3. Observation on 4/2/25 at 8:38 AM revealed Staff C, CNA, and Staff D, CNA transferred Resident #44 from the wheelchair to the bed using a mechanical lift. When Staff C raised the resident out of the wheelchair using the mechanical lift, she failed to leave the wheels of the lift un-braked. When Staff C then lowered the resident into bed using the mechanical lift, she failed to leave the wheels of the lift un-braked. The User Instruction Manual dated 2016 for the mechanical lift indicated the lift has two braked casters which can be applied for parking. When lifting, the casters should be left free and un-braked (the only exception is when lifting a patient from the floor). The lift will then be able to move to the center of gravity of the lift. If the brakes are applied it is the patient that will swing to the center of gravity and this may prove disconcerting and uncomfortable. The Lifting Machine, Using a Mechanical policy dated 2001 failed to follow the User Instruction Manual for the current mechanical lift regarding brake usage. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on observations,resident and staff interviews and policy review the facility failed to ensure proper temperatures for foods served to residents. The facility reported a census of 66 residents. Finding Include: 1. Observation on 4/02/25 at 11:55 a.m., test tray was temped after the last resident on level 1 was served and temperatures were as follows: a. Ham- 103.3 degrees b. Mashed potatoes- 124.8 degrees c. Carrots- 107.1 degrees 2. Observation on 4/02/25 at 12:05 p.m., level 2 room trays were sitting on the kitchen carts ready to pass. Staff A, Certified Nursing Assistant (CNA) began passing meal trays. Staff A verified she was taking meal tray into Resident #59's room. Stopped CNA and had staff check the temperature of the food. The temperatures were as follows: a. Ham- 97 degrees b. Mashed potatoes- 131 degrees c. Carrots- 96 degrees. Kitchen staff removed the tray and returned to the kitchen with the tray to reheat the food to the proper temperature. Interview on 4/02/25 at 12:27 p.m., with the Administrator revealed she expected the food to be served at the safe and proper temperatures. 48004 3. Review of Resident #12's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. During interview on 3/31/25 at 11:04 AM Resident #12 stated the food is disgusting. Resident #12 further revealed the food is cold when it should be hot. 4. Review of Resident #39's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. Interview on 3/31/25 at 1:05 PM with Resident #39 revealed the food is often cold, and it should be hot. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165174	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa DE Paz Health Care Center	2121 West 19th Street Sioux City, IA 51103

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #43's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. Interview on 3/31/25 at 11:39 AM with Resident #43 revealed the food is often cold when it should be hot. 6. Review of Resident #51's MDS dated [DATE] revealed a BIMS score of 13 indicating intact cognition. Interview on 3/31/25 at 11:24 AM with Resident #51 revealed that the food tastes terrible, and that it is cold often when it should be hot. Review of an undated facility provided policy titled, Food Temperatures revealed: a. Hot food temperatures must read no less than 140F when residents are served; cold food temperatures should be below 41F when served.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165174	A. Building B. Wing	04/03/2025

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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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48004 Based on observation, resident interview, staff interview, and policy review the facility failed to provide appropriate infection prevention practices related to contact and droplet precautions for 1 of 3 residents (Resident #39) reviewed. The facility reported a census of 66 residents. Findings include: Review of Resident #39's Minimum Data Set (MDS) dated [DATE] revealed an admitted to the facility of 11/29/24. The MDS further revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Review of Resident #39's Electronic Healthcare Record (EHR) page titled Physicians Orders revealed an order for Capecitabine oral tablet 500mg give 4 tablets by mouth 2 times a day for chemotherapy related to malignant neoplasm of the rectum. Observation on 3/31/25 at 11:30 AM revealed a sign by Resident #39's door stating that Resident #39 was on contact and droplet precautions. Observation on 3/31/25 at 12:47 PM Staff C Certified Medication Aide (CMA) went into Resident #39's room without Personal Protective Equipment (PPE) for contact and droplet precautions. Staff C was observed without a gown, gloves, and no mask. Staff C was observed to pass medications to Resident #39 and left. Interview on 3/31/25 at 1:10 PM with Resident #39 revealed that staff never wear a gown or face shield when coming into the room. Resident #39 revealed he is on some precautions due to going through cancer treatments. Interview on 4/01/25 at 10:54 AM with the Director of Nursing (DON) revealed her expectation would be for gowns and masks to be worn when going into residents rooms with droplet and contact precautions. Review of a facility provided policy titled, Isolation-Categories of Transmission-Based Precautions with a revision date of September 2022 revealed: a. Contact precautions- staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. This document further revealed: b. Droplet precautions- Gloves, gown, and goggles are worn if there is risk of spraying respiratory secretions.