STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165251	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ravenwood Specialty Care	2651 St Francis Drive Waterloo, IA 50702

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, resident interview, staff interview and policy review, the facility failed to ensure call lights were in reach and accessible for 2 of 5 residents (Resident #9 and a confidential source) reviewed for call light use. The facility reported a census of 131 residents.Findings include: On 5/14/26 at 10:04 AM, an observation showed Resident #9's call light lay on the floor at the foot of his bed. He had a reacher (adaptive grabbing tool) on his bed. He sat in his wheelchair and moved about in his room. On 5/12/26 at 12:27 PM, a confidential interview with a resident revealed staff told them there's a call light in the bathroom, but they didn't know where to find it. An observation of the bathroom during the interview showed a call light sat about shoulder height behind the armrest on the toilet. The string on the call light measured approximately 5 inches long, making it inaccessible to the resident when they sat on the toilet. On 5/21/26 at 4:22 PM, an interview with the Director of Nursing (DON) revealed she expected call lights to be in reach and remain accessible to all residents. The Answering the Call Light policy revised March 2021 instructed staff to ensure the call light remained within easy reach of the resident.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, staff, family, and resident interviews, the facility failed to notify the provider when a resident on an antiplatelet medication developed a nosebleed for 1 of 3 residents reviewed (Resident #5) for medications. The facility reported a census of 131 residents.Findings include:Resident #5's Minimum Data Set (MDS) assessment dated [DATE] documented an admission date of 2/14/26. The MDS documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS included a documentation that Resident #5 took an antiplatelet medication (blood thinner). Resident #5's February 2026 Medication Administration Record (MAR) included an order for clopidogrel 75 mg (blood thinner) to give one time a day to prevent blood clots. Staff signed off the medication as given daily from 2/15/26 through and including 2/27/26. The Progress Note written on 2/27/26 at 7:30 AM documented Resident #5 had blood from the nasal area. When the nurse arrived, Resident #5 laid in bed with the head up for an assessment. Once the bleeding stopped, Resident #5 moved into a wheelchair and went about her morning activities. The nurse asked Resident #5 if she wanted to call the doctor or go to the Emergency Department (ED). Resident #5 declined, and said she would have her son take her if she did. She ate her lunch and packed to discharge home. The note lacked documentation of notification to Resident #5's family or provider.The Progress Note written on 2/27/26 at 2:30 PM documented Resident #5 had a swollen nose, with a hairline scratch across the septum (nostril divider) between the nostrils. Resident #5 also had edema (swelling) on both cheekbones below her eyes. Resident #5 reported a nosebleed earlier in the day. The progress note lacked provider notification. The Progress Note written on 2/27/26 at 3:26 PM documented Resident #5's family requested a medical evaluation prior to discharge for the swelling under Resident #5's eyes. The family requested Emergency Medical Services (EMS) transportation to the hospital. The Progress Note written on 2/28/26 at 1:06 AM documented Resident #5 admitted to the hospital with a brain bleed. On 5/18/26 at 1:24 PM, Resident #5's family member reported Resident #5 had a stroke prior to her stay at the facility. She did rehabilitation for a month or so at a local hospital and then discharged home. Once at home, the family decided she needed more rehabilitation, so she admitted to the facility. On 5/19/26 at 3:15 PM, Resident #5 explained she had a bloody nose the morning of discharge, and staff applied an ice pack to stop it. When she stood ready to leave, the nurse prepared her, and she went to the hospital in the ambulance. She explained she went to a different hospital the next morning. She reported she didn't have a brain bleed, she had a stroke previously, nothing new. On 5/14/26 at 3:36 PM, Staff A, Registered Nurse (RN), reported that in a nurse-to-nurse report, the previous nurse reported Resident #5 had a nosebleed prior to his arrival. The family arrived to take Resident #5 home and noticed the swelling under her eyes. When he went in to do his discharge assessment, he agreed with the family that something didn't seem right. He contacted the provider and sent Resident #5 to the emergency department by ambulance. He reported that since Resident #5 took an antiplatelet medication, the provider needed notification when the bleeding occurred to see if they wanted to hold the medication. On 5/21/26 at 4:22 PM, the Director of Nursing (DON) explained Resident #5 shouldn't have a bloody nose, especially while taking the antiplatelet medication. The provider needed notification. The Change in a Resident's Condition or Status policy revised February 2021 instructed staff to notify Resident #5's attending physician or physician on call when there had been an adverse reaction to a medication.

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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 0684 Level of Harm - 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** Based on clinical record review, hospital record review, external clinic record review and staff interview the facility failed to assess a wound and document complete assessments for 1 of 4 residents reviewed (Resident #9). Resident #9 required emergency medical services including a foot amputation. The facility reported a census of 131 residents.Findings include:Resident #9's Minimum Data Set (MDS) dated [DATE] documented an admission date of 3/15/24. The MDS identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS had no documentation of rejection of care behaviors. Resident #9 didn't have bowel or bladder incontinence (loss of control). The MDS included diagnoses of a stroke (blood clot in brain), peripheral vascular disease (poor blood circulation), and diabetes (high blood sugar). Resident #9 didn't have pressure ulcers (bedsores), venous ulcers (leg sores), or arterial ulcers (clogged artery sores). Resident #9 had a diabetic foot ulcer (open sore). Skin and ulcer/injury treatments on Resident #9's MDS included a pressure reduction device for his chair, a pressure reduction device for bed, and applications of ointments or medications to areas other than feet. The treatments on Resident #9's MDS for their feet didn't include a dressing, with or without topical medications. Staff E, Registered Nurse (RN), signed Resident #9's MDS as complete on 3/9/26. Resident #9's April 2026 Treatment Administration Record (TAR) recorded treatment and dressing changes daily, with omissions on 4/12, 4/22, 4/23, and 4/27/26. Resident #9's May 2026 TAR recorded treatment and dressing changes daily, with omissions on 5/1, 5/5, and 5/11/26. The SW - Skin Issues dated 4/6/26 at 4:53 PM documented the right dorsum 1st interdigital space (foot) other skin issue acquired in house. The wound measured 4.19-centimeter (cm) length (l) by (x) 3.18 cm width (w) x 0 depth (d) and an area of 9.91 cm squared (cm2). The wound had no undermining or tunneling. The SW - Skin Issues dated 4/10/26 at 11:47 AM documented the right dorsum 1st interdigital space (foot) other skin issue acquired in house. The note lacked measurements with no tunneling or undermining.The Podiatry Clinic (foot care specialist) note dated 4/10/26 documented Resident #9 had necrotic (dead) tissue debrided (cut away) and needed a right fifth toe amputation (surgical removal). The note described the wound as very painful.The SW - Skin Issues dated 4/15/26 at 11:19 AM documented the right dorsum 1st interdigital space (foot) other skin issue acquired in house. The note indicated the wound deteriorated with measurements of 2.48 cm L x 4.34 cm W x 0 cm D with no undermining or tunneling.The SW - Skin Issues dated 4/21/26 at 7:41 AM documented the right dorsum 1st interdigital space (foot) other skin issue acquired in house. The documentation lacked measurements, but listed no undermining or tunneling.The SW - Skin Issues dated 4/24/26 at 7:42 AM documented the right dorsum 1st interdigital space (foot) other skin issue acquired in house. The documentation lacked measurements but listed no undermining or tunneling.The SW - Skin Issues dated 4/24/26 at 8:40 AM documented the right dorsum 1st interdigital space (foot) other skin issue acquired in house. The note listed the wound healed or closed with continued monitoring and no undermining or tunneling. The Podiatry Clinic note dated 4/27/26 documented an amputation of a gangrenous (dead) toe on the right foot. The Podiatry Clinic note dated 4/28/26 documented a post-operative toe check and that Resident #9's condition eventually required a below the knee amputation. The Podiatry Clinic note dated 5/1/26 documented a post-operative toe check and that Resident #9 continued at high risk for a below the knee amputation. The SW - Skin Issues dated 5/2/26 at 2:12 PM documented the right dorsum 1st interdigital space (foot) listed a surgical wound acquired in house with an unknown progress. The measurements listed 4.19 cm L x 3.35 cm W x 0 cm D. Area measured 15.02 cm2 with no undermining or tunneling.The SW - Skin Issues dated 5/5/26 at 10:45 AM documented the right dorsum 1st interdigital space (foot) listed a surgical wound acquired in house with an unknown progress. The note lacked measurements but reflected no undermining or tunneling.The SW - Skin Issues dated 5/13/26 at 6:06 PM documented the right dorsum 1st interdigital space (foot) listed a surgical wound acquired in house with an unknown (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	progress. The note lacked measurements but reflected no undermining or tunneling.The SW - Skin Issues dated 5/14/26 at 8:52 AM documented the right dorsum 1st interdigital space (foot) listed a surgical wound acquired in house with a stable progress. The wound measured 0.71 cm L x 1.61 cm W x 0 cm D. The area measured 1.21 cm2 with no undermining or tunneling.The SW - Skin Issues dated 5/15/26 at 4:07 PM documented the right dorsum 1st interdigital space (foot) listed a surgical wound acquired in house. The wound lacked measurement but reflected no undermining or tunneling.The Hospital records documented staff transferred Resident #9 to the emergency department (ED) on 5/17/26. ED providers diagnosed Resident #9 with sepsis (serious blood infection) with acute renal (kidney) failure and septic shock (dangerously low blood pressure) due to an unknown organism. Resident #9's foot appeared necrotic (dead tissue) and gangrenous (decaying tissue). The medical providers consulted on Resident #9's lower extremity amputation (surgical limb removal) of either a below the knee amputation (BKA) or an above the knee amputation (AKA). He had an obvious gangrenous infection over his lateral (outer side) right midfoot at the site of the previous amputation. When assessed, the provider noted the wound had complete dehiscence (splitting open) with exposed underlying metatarsal (long foot) bones noted along the fourth and fifth distribution. He had slight peri-wound erythema (redness around a wound) with mild lymphangitis (inflamed lymph vessels) up to his ankle with tenderness and 1 plus pitting edema (swelling). The Hospital records included a note on 5/17/26 that Resident #9 required a below the knee amputation in the operating room on 5/18/26. On 5/19/26 at 12:00 PM, the Director of Nursing (DON) explained staff completed no additional in-house assessments for Resident #9's foot.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interview and policy review the facility failed to provide an adequate intervention after a resident fell for 1 of 4 residents reviewed for falls (Resident #1). The facility used a mechanical lift to get Resident #1 off the floor and into his bed despite complaints of hip pain and not wanting to move his leg. Upon assessment, the hospital found a fracture in Resident #1's leg. The facility reported a census of 131 residents.Findings include:Resident #1's Minimum Data Set (MDS) assessment dated [DATE] listed an admission date of 10/30/25 from home. The MDS identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS indicated Resident #1 had a fall since the prior assessment. He had 1 fall without injury.The Fall Risk Evaluation scores printed 5/21/26 directed to initiate a Care Plan for falls if a 10 or greater. The Evaluations listed the following scores:a.3/16/26: 10b.5/1/26: 11c.5/3/26: 2d.5/8/26: 11The Care Plan Focus initiated 3/16/26 revised 5/11/26 indicated Resident #1 had a risk for falls. The Interventions dated 3/16/26 included the following:a.Encourage Resident #1 to use his call light for assistance.b.Encourage Resident #1 to wear proper footwear.The Care Plan Focus initiated 11/3/25 revised 5/3/26 identified Resident #1 as noncompliant with using his call light and waiting for assistance and would transfer himself. The Interventions directed the following:a.5/3/26: Staff to intervene if they see Resident #1 transferring himself.b.Revised 2/9/26: Ambulation/mobility: None, he required a manual wheelchair for mobility. c.Revised 2/9/26: Resident #1 required an assist of 1 with a front wheeled walker (FWW) per therapy 1/9/25. Encourage wheelchair at time of weakness, unsteady gait, or increased confusion. The Care Plan Focus revised 11/3/25 indicated Resident #1 had a risk for falls related to chronic confusion, shortness of breath, and cardiac impairments, and medication side effects. The Interventions directed the following:a.11/3/25: Anticipate and meet his needs.b.11/3/25: Be sure his call light is within reach and encourage him to use it for assistance as needed. He needed prompt response to all requests for assistance. c.11/3/25: Follow facility fall protocol.d.11/3/25: Review information on past falls and attempt to determine the cause of falls. Record possible root causes. After remove any potential causes if possible. Educate him, his family, caregivers, and the interdisciplinary team (IDT) as to the cause.e.11/7/25: Ensure he wore appropriate footwear when ambulation or mobilizing in the wheelchair. f.11/7/25: Post fall, rearrange room to maximize living space. g.3/18/26: Post fall, offer assistance to the bathroom after meals.h.5/4/26: Post fall, visual cue in room to remind him to use his call light and wait for staff assistance for transfers. The Progress Note written on 5/3/26 at 11:45 AM documented Resident #1 lay on the floor, banging on the door with his foot. He reported to the nurse as he headed to the bathroom, he fell. He rated his pain a 10 out of 10 in his left hip. The assessment showed his left hip had redness and mild swelling. Resident #1 didn't want to bend his left leg due to the pain. The staff transferred Resident #1 to the Emergency Department via ambulance. The Progress Note written on 5/3/26 at 6:09 PM documented the hospital admitted Resident #1 for a hip fracture (broken bone) and possible surgery. In a statement written on 5/5/26 about the fall, Staff B, Licensed Practical Nurse (LPN) documented she last saw Resident #1 eating his breakfast in bed, while passing medications. Resident #1 reported to the nurse he had to go to the bathroom and lost his balance. She assessed him, and he screamed due to pain. The staff used the mechanical lift to get him up. Resident #1 wasn't incontinent and didn't wear shoes or gripper socks. On 5/12/26 at 8:51 AM Resident #1 explained he fell when he headed to the bathroom. He reported he didn't turn on his call light. He further explained there's no point in using it since it can take a couple of hours for staff to answer it. He explained the staff used the mechanical lift to get him off the floor. He added the nurse didn't do range of motion (ROM) (joint movement exercises) to him while on the floor prior to getting him up. On 5/18/26 at 4:37 PM Staff B explained as she passed medications, she heard a banging noise. She (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	found Resident #1 laying on the floor between the door and the dresser. He reported to her he headed to the bathroom. He hadn't used his call light. She explained she went to get the equipment to take vitals and when she came back, he complained of hip pain. He complained of hip pain while on the floor. They used the mechanical lift to get him up off the floor and into bed. Once in bed he continued to complain of pain and didn't want to bend or move that left leg. She explained that she hadn't seen Resident #1 walk so she assumed he required a mechanical lift transfer. She explained normal protocol dictates getting someone up when they fall, even if they complain of pain. On 5/21/26 at 11:58 AM the primary care provider (PCP) explained that while she didn't see the x-rays, she didn't believe this represented a major injury. The fall and the nature of the injury led her to assume the fracture resulted from the fall. On 5/21/26 at 4:22 PM the Director of Nursing (DON) explained she expected an assessment to be completed post fall including vital signs, hand grips, looking for hip rotation, skin alterations, and if it stayed unwitnessed or if they hit their head, neurological assessments. She further explained that if a resident complained of pain and didn't want to move an extremity, staff should make them as comfortable as possible, leave them on the floor, and wait for the Emergency Medical Technicians (EMTs) to arrive. The Falls-Clinical Protocol policy revised March 2018 directed staff to assess, document, and report musculoskeletal function, observing for any change in normal ROM.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, resident, and staff interviews the facility failed to answer call lights in a timely manner. This resulted in residents to not use the call light, being forgotten on the toilet, and unable to seek assistance when needed for 4 of 5 residents (Residents #1, #3, #10 and a confidential source) reviewed for call lights. The facility reported a census of 131 residents.Findings include: 1. On 5/12/26 at 8:51 AM, Resident #1 explained he recently had a fall. He reported he didn't use his call light to call for assistance when he needed to use the restroom. He explained there's no point in turning it on as it can take a couple of hours for staff to answer it. 2. On 5/12/26 at 9:21 AM, Resident #3 reported one night she vomited due to acid reflux (stomach irritation) and turned on her call light. She reported no one came into her room for 4 hours, until the next morning. When she reported it to a nurse and staff, they didn't have an explanation why someone didn't answer her call light. 3. On 5/12/26 at 12:27 PM, a resident during a confidential interview explained they've to use the call light 3 to 4 times to get any help. They explained sometimes they do things for themselves that they aren't supposed to do because help doesn't come. The resident stated, they'd get their butt chewed for it, but if they got to go, they got to go. The resident explained staff forgot them in the bathroom [ROOM NUMBER] times in the last month and a half, long enough for their buttocks to go numb. They explained they're unable to find the call light in the restroom to call for help. An observation of the restroom during the interview revealed a call light with a short string, approximately 5 inches long, at shoulder height behind the armrest. 4. On 5/14/26 at 9:14 AM, Resident #10 explained he didn't use his call light. He added he can see out into the hall and just waves someone down when they go by or he calls out. He reported it's faster than waiting for someone to answer his call light. On 5/14/26 at 11:20 AM, Staff D, Certified Nurse Aide (CNA), explained call lights are to be answered right away but up to 15 minutes if a person's busy with another resident. On 5/18/26 at 2:37 PM, Staff B, Licensed Practical Nurse (LPN), explained call lights should be answered in a maximum time of 10 minutes. She explained if the CNAs are busy, the nurse's supposed to answer the lights. On 5/19/26 at 9:59 AM, Staff C, Registered Nurse (RN), explained she wasn't sure what the maximum time allowed for answering a call light was, just as soon as possible. On 5/21/26 at 4:22 PM, the Director of Nursing (DON) explained the maximum allowable time frame for answering a call light's 15 minutes. The Answering the Call Light policy revised March 2021 instructed staff to ensure timely responses to the resident's requests and needs.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on clinical record review, policy review, resident and staff interviews, the facility failed to ensure staff followed physician orders for dressing changes, failed to provide appropriate assistance to a resident that fell, failed to notify all staff when a resident should be on contact precautions and failed to ensure staff washed their hands properly for 2 of 5 nurses reviewed. The facility reported a census of 131 residents.Findings include:1. Resident #9's May 2026 Treatment Administration Record (TAR) directed staff to apply Povidone-Iodine solution 10% to the right foot daily on the day shift (6:00 AM to 2:00 PM) for place gauze per podiatry. The documentation reflected staff completed the treatment daily except 5/1/26, 5/5/26, and 5/11/26. The documentation included to see the progress notes on 5/12/26 and 5/17/26. On 5/18/26 at 2:37 PM and 5/21/26 at 11:12 AM, Staff B, Licensed Practical Nurse (LPN), explained she performed a dressing change to Resident #9's right foot on 5/16/26. She confirmed during both interviews that she completed the dressing change at bedtime and both dressing changes involved the iodine gauze treatment. The Wound Care policy revised October 2010 instructed staff to verify the physician's order for the procedure. On 5/21/26 at 4:22 PM, the Director of Nursing (DON) explained that staff should not perform dressing changes that lack an order. 2. The Progress Note written on 5/3/26 at 11:45 AM documented Resident #1 fell in his room. The progress note documented a 10/10 pain rating in his left hip. He had some redness and mild swelling in his left hip. Resident #1 refused to bend his left leg due to pain. The Progress Note written on 5/3/26 at 6:09 PM documented the hospital admitted Resident #1 for a hip fracture (broken bone) and possible surgery. On 5/12/26 at 8:51 AM, Resident #1 explained on the day he fell, staff assisted him up off the floor with the mechanical lift. He explained the nurse skipped range of motion prior to getting him off the floor. On 5/18/26 at 2:37 PM, Staff B explained Resident #1 complained of pain in his left hip after he fell, while he lay on the floor. She explained they used the mechanical lift to get him up off the floor and into bed. She further explained it was normal protocol to get someone up off the floor when they fall, even if they complain of pain. The Falls - Clinical Protocol policy revised March 2018 lacked direction to staff for what to do in the event of a fall with complaints of pain and swelling of a joint. On 5/21/26 at 4:22 PM, the DON explained if a resident complained of pain and refused to move an extremity, she expected staff to make the resident as comfortable as possible, leave them on the floor, and wait for Emergency Medical Technicians (EMTs) to arrive.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, clinical record review, facility policy review, and staff interviews, the facility failed to maintain effective infection control and isolation procedures for 1 of 3 residents reviewed (Resident #7), specifically regarding contact precautions and hand hygiene during care for a resident with an infectious disease. The facility reported a census of 131 residents. Findings include: The Progress Note written on 5/7/26 at 9:35 AM documented the Advanced Registered Nurse Practitioner (ARNP) gave a verbal order to collect a stool sample from Resident #7 for Clostridium difficile (C. diff) (severe bowel infection) due to prolonged diarrhea and a history of C. diff infection. The Provider Encounter Note dated 5/7/26 documented the stool sample came back positive for C. diff. The staff placed Resident #7 on contact precautions, and started them on an antibiotic. The SPN - Focused Evaluation dated 5/11/26 at 9:11 PM reflected Resident #7 received treatment for C-diff and had 1 loose stool that shift. He reported his stomach remained tender.The SPN - Focused Evaluation dated 5/13/26 at 10:23 PM indicated Resident #7 continued to take medication for C-diff. He denied abdominal pain and didn't have loose stools reported on that shift.The Physician Order written 5/11/26 directed Resident #7 to stay in contact isolation precautions, with all treatments, medication passes, therapy, activities, and meals occurring in their room. On 5/13/26 at 8:58 AM, Staff F, Registered Nurse (RN), entered Resident #7's room wearing a gown and gloves. After explaining the plan to Resident #7, she began their dressing change. The procedure included filling the sink with soapy water and placing clean washcloths in the sink, without a barrier. She drained the soapy water, used running water to rinse a washcloth to clean Resident #7's legs, and reused it, only changing cloths when cleaning the other leg. Before doing the treatment, she removed her gloves, rinsed her hands under running water, turned off the water with a wet hand, dried her hands, and put on clean gloves. After doing the treatment, she removed her gloves, washed her hands with soap, turned off the water with a wet hand, dried her hands, and applied clean gloves. At the end of the procedure, she removed her gloves and sprayed the sink with a disinfectant that didn't list C. diff as an organism it killed. On 5/14/26 at 1:09 PM, Staff F explained when caring for a resident with C. diff, staff must wash their hands. She acknowledged handwashing included turning off the faucet with a paper towel. She explained a resident with C. diff required isolation to their room and signage belonged on the door. She explained the dressing change included her usual practice, and it's normal for her to use the sink as a basin. She didn't know if the disinfectant needed to sit on a surface for a specific amount of time before being wiped off. On 5/14/26 at 2:56 PM, watched Staff H, RN, place a contact precaution sign on Resident #7's door. On 5/14/26 at 2:58 PM, Staff G, Licensed Practical Nurse (LPN), explained staff should've placed Resident #7 on isolation at the time they suspected they had C. diff. She added hand washing required soap and water. On 5/14/26 at 5:17 PM, Staff I, housekeeper, explained she didn't use a specific cleaner for infectious rooms. She explained she hasn't encountered a room bad enough to wear a gown. She added if she knew a resident was infectious, she'd wear a gown. On 5/14/26 at 5:35 PM, the Administrator explained she didn't know if the facility had a product in house that would appropriately disinfect against C. diff. She explained the disinfectant used by Staff F didn't work against C. diff. On 5/14/26, the Administrator explained they did have a product in house that would kill C. diff, and it sat on the housekeeping carts. On 5/21/26 at 4:22 PM, the Director of Nursing (DON) explained she expected staff to wash their hands with soap and water in a room with a resident with C. diff. She explained she expected the staff to turn off the water with a paper towel during handwashing. She explained if a washcloth becomes soiled while cleaning wounds, the staff should use a new washcloth instead of rinsing and reusing it. She explained during wound care the staff should use a basin, not the sink, to hold water.