STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165509	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Alverno Health Care Facility	849 13th Avenue North Clinton, IA 52732

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 48374 Based on clinical record review, staff interview, resident interview, and resident handbook review, the facility failed to implement their policy when the Administrator implemented a grievance resolution of assisting the resident to organize his money and gift cards in a locked drawer in the resident's room in regards to missing property and possible theft for 1 of 1 resident reviewed (Resident #43). The facility reported a census of 88 residents. Findings include: The undated Admission Minimum Data Set (MDS), documented an entrance date of 1/26/2024 for Resident #43 and identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated cognition intact. The MDS reflected the resident was able to make themselves understood and understood others. The Care Plan dated 1/29/2024 with a focus area of Person Centered Care Status: Active (Current) with the goal: to promote my quality of Life. The Care Plan documented the following interventions: a. I know this plan of care had been written to promote my quality of life, however there may be times I choose to exert my individual rights by making my own independent choice i.e. refusal of care, treatment and diet. My resident summary is an extension of my care plan. b. I prefer to have my bed against the wall to allow for more moveable space in my room. The Progress Notes lacked documentation regarding the missing property, the outcome of an investigation and any information regarding reimbursement. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165509	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/29/2024 6:45 PM Resident #43 advised he and his wife had some money in their drawer and that came up missing. Resident #43 believed it was between $60 to $80 dollars but is unsure of the exact amount. The Resident advised at the same time they were also missing approximately $300 in gift cards for Taco Bell and Wal-Mart. Resident #43 indicated this was approximately 2 weeks ago. The Resident advised he talked to the facility Administrator and several other staff members and a police report was made. The police came out to the facility and interviewed him. The resident advised he did not know if it was a resident or staff that took their money and gift cards. He advised he and his wife searched his room to make sure they hadn't misplaced them. Facility staff also came in and searched the room with his permission. Resident #43 was unable to specifically name any particular staff member he talked to other than the Administrator. He then inquired on whether they are able to get a camera for their room. During an interview on 4/30/24 10:46 AM The Administrator reported she was aware of the missing property/theft concern with this resident. The Administrator shared that prior to the incident the resident asked her if he was able to purchase gift cards because he was afraid he was running out of money. The Administrator shared she told the resident he could purchase gift cards just to be careful/mindful of the spend down limits. The Administrator advised she completed the 5 day investigation and also wrote up the concern as a grievance. The Administrator advised the resident always said missing money and didn't say theft. She advised staff looked through the resident's room and didn't find the missing property. The Administrator further shared, In January, the resident asked about gift cards and I told him to be careful for the look back of 5 years. I did not know he had cash or gift cards. The top cabinet door on the stand between their chairs wasn't locking because they did not have the right key so we provided a key that would work. The Administrator advised she asked other residents if they had any missing property. When queried, the Administrator advised she did not interview staff about the incident and did not inquire whether staff were aware the resident had money and gift cards in his room. On 4/30/24 at approximately 3:30 PM the administrator was queried if the facility had a plan to replace the missing items. The Administrator advised, at this time, there is not a plan to replace or reimburse the missing property. The Administrator was then asked if she had talked with any family members who may have assisted the resident in acquiring the gift cards and she replied she had not. The Administrator then shared she felt very comfortable with the conversations she had with the Resident. When asked, the Administrator advised the facility does not have a policy for missing or stolen items. The Administrator was asked for and provided the abuse policy. The Administrator also provided a document pertaining to the facility's investigation. The undated, untitled and unsigned document reads as follows: 5 day follow up investigation. The Resident continued to allow staff to search in his room. We did have nurse management be the one to help search for the items. Other gift cards were found lying in different places but none of the gift cards that the Resident reported missing were found. Police were notified and we have an open investigation on it. We encouraged the Resident to keep all his money and gift cards in the top drawer of the bed side cabinet. This cabinet can be locked he had a key, but we could not get it to work. We provided resident with the correct key, and he said he will keep the key in safe keeping and not tell anyone. We will work with him as long as he allows to help get all his valuable items in his locked boxes he has. Staff will be educated on encouraging residents to keep valuables in a locked and safe place. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator also provided the following hand written note; I talked to three residents and all 3 deny having any concerns or missing items. I randomly picked one person from each section on the unit.-Staff G. The following document was also provided; 4/23/24 I, Staff G, Staff F, and Staff H with resident permission searched the Resident's room for the reported missing money and gift cards. During the search we found several gift cards, money ($2 bills, coins), various legal documents, bank statements, and check books unsecured through out the room stored in various places. The gift cards and money found were not the ones reported missing. We also identified the resident had two locked safe boxes with the keys stored in the lock. Staff G provided the resident with education on the need to get these items organized and locked. Staff G also provided resident with a lanyard to store the keys for the safe boxes and locked nightstand drawer. The resident was very nonchalant about the situation and stated, what are you going to do? this statement was rhetorical. Signed by Staff G and Staff F. On 05/01/24 at 8:20 AM Resident # 43 and his wife were observed in the main dining room. This worker again talked with the resident about the missing money and gift cards and he indicated he could not name any staff member specifically that usually works with them because the staff members always vary and no one staff member worked them more than another. They have not had any other items go missing. On 05/01/24 at 1:15 PM Staff I, Licensed Practical Nurse (LPN), was queried about the missing property. She indicated she thought the incident happened about one week ago. She was made aware of the incident by staff J, Certified Nursing Assistant (CNA). Staff J and myself assisted in helping Resident #43 look for some missing property. Staff I did not remember exactly but thought they were looking for several gift cards and some cash. Staff I advised she made the DON aware of the incident and that the DON informed the Administrator. Staff I advised she made management aware of the missing items the same day she learned about it. Staff I also shared she was not aware of the gift cards or money prior to the incident. She was not aware of any other prior instances. On 05/01/24 at 1:20 PM Staff K, Certified Nursing Assistant (CNA), was queried about the incident. She advised Resident #43 told her about the money and gift cards after someone had stolen them. That same day the police came in and talked with the resident. She was not told how much money was missing or what denomination the gift cards were. The resident said a lot of money but I didn't know what that meant. Not aware of management interviewing any staff. Was not aware of the money or cards prior to the incident. Hasn't heard any staff talking about it or any rumors. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/01/24 at 1:31 PM The facility Director of Nursing (DON), was interviewed regarding Resident # 43's missing property. The DON advised it was reported the resident was missing money or gift cards. Staff J told her about it and Staff J and Staff L CNA, went in the resident's room and with his permission helped look for the missing property. The DON then notified the Administrator and then she and I went through some things with his permission. The resident provided varied amounts of money missing. The resident reported he was also missing at least one gift card and that may have been for Taco Bell. The DON shared they did locate some gift cards and those were found just sitting in a drawer not locked up or anything. The DON continued by saying staff asked other residents and no one reported anything missing. Incident was on Monday the 22nd. The DON shared, to her knowledge there have never been any issues with theft in the past. When queried, the DON advised she does not know if a facility investigation including staff was conducted. 4/22/24 Grievance/Complaint Report filed by the resident. Grievance/Complaint Staff member J CNA asked if she could organize a few things in the bathroom closet-and the resident responded yes. Then the resident disclosed he was missing some things out of his drawer between the chairs. Money and gift cards. Documentation of Facility Follow-Up: Individual designated to investigate/take action on this concern: Administrator and Nursing Staff 4/23 Reported to DIA-Resident thinks a total of $60 to $70 dollars cash and a $100.00 Taco Bell gift card and$ 50.00 Wal-mart gift card. Notified the Police, came in to review and the resident allowed staff to do a deep clean in room-other gift cards found laying around in various areas- Resolution of Grievance/Complaint: Help the Resident organize his money and gift cards and put them in the top draw-start using the key we provided for locking the cabinet. On 5/1/2024 at 5:55 PM a phone interview was conducted with Staff L CNA. She advised she really didn't know much about the situation other than her co-worker staff J ,came and got her and asked her to help her look for a few things in Resident #43's room as he was missing some money and gift cards. Staff L shared they did not find the items the resident reported missing. She was not aware that the resident had money or gift cards in his room and does not know if any other workers or residents were aware of the money or gift cards in the resident's room. On 5/02/24 at 08:06 AM Staff F RN/MDS Coordinator 1 was interviewed. Staff F advised a few CNA's had already went in and looked through the room with the resident's permission and did not find the missing items. Staff F, Staff G, and Staff H all three went in and again with the resident's permission went though the resident's possessions looking for the missing items. Staff F initially I found a tote with bank statements, legal documents, and other items. In the night stand a few gift cards were found but they were not the ones reported missing. Resident #43's wife's wallet and bank card were found. Also, in the resident's nightstand two small safes with the keys still in the locks were located. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff F then shared she did not specifically write an all inclusive Progress Note about the missing property but did document the resident was issued a new debit card and he had asked her to shred the old one. Staff F advised she checked with other residents regarding missing items and no one identified any concerns. Staff F was not sure if staff on that floor were formally interviewed but she assumed the Administrator would have completed interviews. Staff F shared there were some inconsistencies with amount of money and gift cards the resident reported missing. To her knowledge, there had never been any concerns with staff/theft etc. The night stands in the resident rooms lock but we encourage them to keep there money in the resident trust fund. Staff F was not aware the key the resident had was the wrong key for that night stand. On 05/06/24 at 11:52 Staff J CNA/Certified Medication Aide (CMA), was interviewed. When queried about the incident Staff J advised she was organizing Resident #43's bathroom closet and the resident told her maybe she could organize this drawer next because he thought he was missing something. At first when the resident told her about it he started with approximately 50 to 60 dollars missing and the amount kept going up and he advised he was also missing some gift cards. Staff J advised she then went and got Staff L and they reported the concern to the DON. Then Staff L and myself looked all over the room and did not locate the missing property. After that the Administrator took over. Staff J advised prior to the incident she was aware the resident had coins in his room and she knew he had some gift cards. Staff J did not know if other staff had knowledge of the money or gift cards. The first few days the resident moved to 2nd floor from 1st floor there were a lot of people in and out helping them get settled. After the incident occurred Staff J learned the lock on the drawer did not work and reported this information to the Administrator. The resident was educated if he had anything of value he could be lock it up in the medication room or he should keep it up front. When queried,Staff J advised facility staff were provided education for staff last week while the State Surveyors were in the building. The Facility Resident Handbook dated 5/1/2019 page 26 of 42 Section Q. Money & Other Valuable Items documents the following: Our Community does not accept responsibility for the loss or theft of money or valuables. Thus, jewelry and other valuables should not be kept in your room. You may, however, create a Resident Trust account with us by contacting the Business Office during regular business hours.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 41537 Based on record review and staff interviews the facility failed to ensure 1 of 1 residents newly admitted to the facility Preadmission Screening and Resident Review (PASRR) accurately reflected his admitting diagnosis (Resident #44). The facility reported a census of 88 residents. Findings include: Record review of Resident #44 current PASRR dated 1/22/24 informed he had no mental health diagnosis known or suspected, no mental health symptoms, and not on medications for his mental health. Record review of Resident #44 Diagnosis report dated 5/1/24 documented he was admitted to the facility with the following diagnoses on 1/24/24: a. Unspecified psychosis not due to a substance or know physiological condition b. Anxiety c. Depression Record review of Resident #44 current Care Plan dated 5/1/24 documented the following Problem: a. Behavior: Resident #44 has a diagnosis of anxiety and is taking medication. He has displayed mood/behavior changes related to dementia. He has delusions which can cause him to become agitated such as thinking there are people in his house or holding him against his will. He has become physically and verbally aggressive towards staff when they have attempted to calm and re-direct. During an interview on 5/2/24 at 11:31 AM with the facilities Social Worker revealed Resident #44 received the diagnosis of depression and anxiety on 1/29/24. She then informed if a diagnosis was new she would update the PASRR right away but obviously missed it for Resident #44.

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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. 48452 Based on observation, resident interviews, staff interviews, and policy review the facility failed to respond to resident's needs within the required fifteen minute time frame when residents activated their call lights. Call light observations revealed 5 of 11 call lights exceeded the fifteen minute response time (Resident #19, #4, #5, #15, and #61). The facility reported a census of 88 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #19 signed 3/19/24 documented a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The resident had diagnoses including peripheral vascular disease, arthritis, and renal disease. The MDS revealed the resident required partial to moderate assistance for bathing, dressing, personal hygiene, and laying down as well as occasional bladder incontinence. On 5/1/24, observed Resident #19's call light was on from 6:53 AM to 8:15 AM. The call light system screen was in the hallway next to the medication cart. At 8:15 AM on 5/1/24 Staff D, Licensed Practical Nurse (LPN) stated the resident scratched her eye and wanted eye drops. He was not aware the resident's light was on since 6:53 AM. He confirmed his shift started at 7:00 AM. During an interview on 5/1/24 at 8:16 AM the resident stated she scratched her cornea while adjusting her hat and demonstrated. She said she put her call light on for help getting eye drops to relieve the discomfort. She stated someone answered the light earlier, told her what she wanted was a problem for the nurse, and then they left. The resident said she kept the call light on because this has happened between shifts before and she did not know if the message was passed along. Resident #19 then stated some staff turned the call lights off and back on again if they didn't help. 2. The MDS for Resident #4 signed 3/21/24 documented a BIMS score of 13 which indicated intact cognition. Diagnoses included atrial fibrillation, muscle weakness with pain in the right hip, and asthma. The MDS revealed the resident needed substantial/maximal assistance for lower body dressing, bathing, and toileting with occasional bladder incontinence. On 5/1/24 at 11:52 AM Resident #4 stated sometimes call lights took a long time. She said that there have been a few times she has been 'naughty' when she really had to go and it took too long, and confirmed that meant she went to the bathroom on her own to avoid incontinence. She said she knew staff were busy. 3. The MDS for Resident #5 signed 3/22/24 documented a BIMS score of 13 which indicated intact cognition. Diagnoses included chronic pain, heart failure, and anxiety. The MDS revealed the resident required substantial to maximal assistance for bathing, dressing, personal hygiene, and toileting as well as occasional incontinence of bowel and bladder. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/30/24, observed Resident #5's call light was on from 7:25 AM to 7:41 AM. The call light system screen was in the hallway near the medication cart. During an interview on 4/30/24 at 8:40 AM the resident stated call lights were answered very slowly. Sometimes very very slowly. She stated she tried to only use the call light when necessary, so she usually needed the bathroom when she pushed it. She had a clock on the wall that faced her bed, and indicated that on 4/28/24 she pushed her call light to use the bathroom for a bowel movement and no one answered for two hours before she fell asleep. Resident #5 stated she woke up at 4:00 AM and still needed to have a bowel movement, and at that time also needed pain medication. 4. The MDS for Resident #15 signed 2/20/24 documented a BIMS of 13 which indicated intact cognition. Diagnoses included neurogenic bladder, renal disease, and heart failure. The MDS revealed the resident required substantial/maximal assistance for lower body dressing and toileting, and partial to moderate assistance for bathing upper body dressing. The resident had an indwelling catheter. On 4/30/24, observed Resident #15's call light was on from 7:24 AM to 7:41 AM. The call light system screen was visible in the hallway. A document titled Grievance/Complaint Report dated 2/22/24 documented a complaint of long call light times. It included documentation of the resident's call lights from 2/12/24 through 2/19/24. Call lights over 15 minutes were documented once on 2/13, 3 times on 2/14, 3 times on 2/15, and once on 2/16 with 6 of them over 20 minutes. 5. The MDS for Resident #61 signed 3/19/24 documented a BIMS score of 9 which indicated moderately impaired cognition. The resident had diagnoses including heart failure, fibromyalgia, and arthritis. The MDS revealed the resident required substantial/maximal assistance lower body dressing and personal hygiene, and partial to moderate assistance for upper body dressing. Toileting required supervision or touching assistance and the resident was occasionally bowel and bladder incontinent. On 5/1/24, observed Resident #61's call light was on from 7:15 AM to 7:35 AM and 7:36 AM to 7:45 AM. The call light system screen was visible in the hallway. On 5/1/24 at 1:58 PM the Administrator stated she was not able to run a call light report from their computer system. An interview with Staff E, Licensed Practical Nurse (LPN), on 5/2/24 at 7:28 revealed staff answer call lights as quickly as possible. She stated they do the best they can. An interview with Staff D, LPN, on 5/2/24 at 7:43 AM determined he expected call lights to be answered in 2-5 minutes. He did not know if there was a call light policy and stated his job description indicated they should follow standard of practice. On 5/2/24 at 8:02 AM the Director of Nursing stated they have done call light audits because they heard in their neighborhood meetings this was an issue. She expected call lights to be answered within 10-15 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A policy titled Answering Call Lights, reviewed/revised August 2021, advised staff to answer the call lights as soon as possible. The policy lacked documentation of the required 15 minute response time.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48452 Based on observation, interviews, and policy review the facility failed to ensure medications were disposed of in a safe, secure manner. Facility staff missed the medication cup with two pills and disposed of them in the garbage can on the medication cart, giving 18 residents on the floor access to unsecured medication. The facility reported a census of 88 residents. Findings include: During a medication cart observation on 4/30/24 at 7:51 AM, on the first floor, Staff C, Certified Medication Aide (CMA) prepared medications for a resident. While pushing them through the back of the medication card, the resident's Pantoprazole 40 mg and Metoprolol 50 mg landed on the cart. Staff C disposed of the medications in the garbage can on the medication cart. She pushed replacement pills from the same cards into the cup and carried them to the resident's room. The medication cart was unattended. Staff C, during an interview on 4/30/24 at 8:03 AM, stated she usually disposed of medications in the Sharps container or garbage can when they were not given to the resident. During an interview with Staff E, Licensed Practical Nurse (LPN) for floor 2, on 5/2/24 at 7:25 AM stated she usually disposed of medications that could not be given to a resident in the Sharps container. She stated for some medications she used drug buster that was stored in the locked medication room. On 5/2/24 at 7:43 AM Staff D, LPN on floor 3, stated he disposed of medications that could not be given to a resident in the garbage or Sharps container. An interview with the Director of Nursing on 5/2/24 at 8:02 AM revealed she expected staff to dispose of medications using drug buster, available in all three secure medication rooms. She was not aware they were throwing them away or using the Sharps container. Facility policy, titled Medication Administration and dated May 2008, documented the Director of Nursing was responsible for the supervision and director of all personnel with medication administration duties and function. The policy lacked documentation of procedures for medication disposal.

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 41537 Based on record review and staff interview the facility failed to ensure 1 of 1 residents as needed (PRN) anti-psychotic medication was reviewed by his Primary Care Provider (PCP) every 14 days or discontinued (Resident #45). The facility reported a census of 88 residents. Findings include: Record review of a Consultation Report dated 4/2/24 documented a rational to continue use of Seroquel 12.5 PRN - justified on 4/3/24 with rationale but nothing in the following 14 days to renew and still. The form also instructed the following: Rationale for Recommendation: Centers of Medicare and Medicaid Services (CMS) requires PRN orders for anti-psychotic drugs be limited to 14 days. A new order should not be written without the prescriber directly examining the resident and assessing the resident's conditions and progress to determine if the PRN anti-psychotic is still needed. Report of the residents condition from facility to the prescriber does not meet the criteria for an evaluation. Record review of Resident #45 April Medication Administration Record (MAR) documented he received his PRN anti-psychotic medication after it should of been discontinued on 4/17/24 (14 days) due to no documentation for continued use on: 4/18/24 at 10:06 AM 4/22/24 at 1:23 PM 4/24/24 at 1:05 PM - No effect 4/25/24 at 1:44 PM 4/29/24 at 12:11 PM During an interview on 5/2/24 at 11:31 AM with the facilities Social Worker revealed she was aware of 14 day PRN anti-psychotic and need for renewal, but his family is very adamant they want that available for him. During an interview on 5/2/24 at 11:00 AM - 11:38 AM with Staff G, Registered Nurse/MDS Coordinator 2 revealed she was aware of a requirement for PRN medications such as anti-depressant and anti-psychotics that need to be reviewed every 14 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165509	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Alverno Health Care Facility	849 13th Avenue North Clinton, IA 52732

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41537 Based on record review, observations, and staff interviews the facility failed to ensure a hand-washing sink was present in 3 of 3 laundry rooms that contained washers and dryers that staff used to transfer presorted clothes from laundry hampers into the washer. The facility reported a census of 88 residents. Findings include: Record review of a document titled, FAQs for Clinicians about C. diff (also known as Clostridioides difficile or C. difficile (a germ (bacterium) that causes diarrhea and colitis (an inflammation of the colon) dated 10/25/2022 on the Centers for Disease Control and Prevention (CDC) instructed the following when taking care of a patient with C. Diff: a. Wear gloves and a gown when treating patients with C. diff, even during short visits. Gloves are important because hand sanitizer doesn't kill C. diff and hand-washing might not be sufficient alone to eliminate all C. diff spores. During a continuous walk through of the facility completing observations of each floor (3) designated laundry areas on 5/1/24 at 10:01 AM to 10:32 at AM revealed the following: a. First Floor room that held the washing machines and dryer did not have a hand-washing sink. b. Second Floor room that held the washing machines and dryer did not have a hand-washing sink. c. Third Floor room that held the washing machines and dryer did not have a hand-washing sink. During an interview with Staff A, Environmental Services (EVS) on 5/1/24 at 10:10 AM revealed she has worked at the facility for approximately [AGE] years and they have never had a hand-washing sink in the three rooms the washing machines are in. When asked how she would wash her hands after placing soiled items such as isolation materials for C. diff reveled they use gloves and proper Personal Protective Equipment (PPE) (worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) and then hand sanitizer that is on the wall in the room. She then informed if she had to wash her hands with soap and water she would have to touch the door to go out and then another door to go into the soiled utility room to wash her hands. During the survey no residents had C. diff.