STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175541	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tallgrass Creek, Inc	13760 Metcalf Avenue Overland Park, KS 66223

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45668 The facility identified a census of 42 residents. The sample included 13 residents with one resident reviewed for dignity. Based on observation, interview, and record review, the facility failed to provide a dignified care environment for Resident (R)23. This placed R23 at risk for impaired dignity and quality of life. Findings Included: - R23's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), cognitive-communication disorder, dysphagia (difficulty swallowing), and aphasia (difficulty speaking). R23's Quarterly Minimum Data Set (MDS) completed 03/27/24 indicated a Brief Interview for Mental Status (BIMS) was not completed due to severe cognitive impairment. The MDS indicated she required maximal assistance with bed mobility, transfers, dressing, personal hygiene, and bathing. The MDS indicated she had unclear speech and was rarely understood. R23's Dementia Care Area Assessment (CAA) completed 12/26/23 indicated she was severely impaired related to her advanced dementia and aphasia. The MDS indicated she was at risk for potential miscommunications of safety cues and at risk for falls and injuries. The CAA noted care planned interventions would be implemented to compensate for communication impairments and reduce the risk associated with her impairments. R23's Care Plan initiated on 12/26/23 indicated she required extensive staff assistance for transfers, bathing, toileting, personal hygiene, and dressing. The plan indicated she had a history of falls from her bed. The plan indicated her bed was to be placed in the lowest position with a fall mat on the floor next to her bed. The plan indicated her door was to be left open unless personal care was being performed. On 05/06/23 at 07:45 AM an inspection of R23's room revealed her door open. R23 slept in her bed. Her bed was in the lowest position. A fall mat was placed on the floor left of her bed. R23's covers were pulled up over her upper body. Her lower body was exposed and she had only an incontinence brief covering her. R23 was visible from the hallway as she slept with the door open. She remained in the same position until she was awoken by staff for breakfast at 09:15 AM. Multiple residents and staff walked by R23's room during the observation period. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/24 at 10:10 AM Certified Nurse Aide (CNA) M stated staff were expected to check on the resident at least every two hours but she preferred to check in with the residents every 30 minutes. She stated R23 would often pull her covers down or off but staff should be monitoring her and attempt to cover her up. On 05/08/24 at 10:23 AM Licensed Nurse (LN) G stated cognitively impaired residents should never be left uncovered or exposed. She stated staff should be checking them frequently to ensure they did not need care or assistance. She stated R23 could move herself around in bed and adjust her covers if she wanted. On 05/08/24 at 12:20 AM Administrative Nurse D stated R23's staff should have checked in on her every couple of hours to ensure she was not left exposed or repositioned her covers. The facility's Resident Rights policy 06/2023 indicated the facility will promote and protect each resident's rights to be treated with respect and ensure dignity. The facility failed to provide a dignified care environment for R23. This placed R23 at risk for impaired dignity and quality of life.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45668 The facility had a census of 42 residents. The sample included 13 residents with two reviewed for accidents. Based on observation, record review, and interview, the facility failed to ensure a safe environment free from hazardous materials for nine cognitively impaired independently mobile residents. The facility additionally failed to ensure an environment free from avoidable accidents for Resident (R)15 who was injured during a lift-assisted transfer. This deficient practice placed the residents at risk for preventable accidents and injuries. Findings Included: - On 05/06/24 at 07:10 AM an initial walkthrough of the facility was completed. An inspection of the west hall's laundry room revealed the door was unlocked. An inspection of the room revealed a bottle of Oxivir-TB spray (disinfectant that kills bacteria and viruses) left on top of the washing machine. The bottle contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed. An inspection of the west hall also revealed an unlocked spa room. The spa room contained an unlocked cabinet with disposable ice packs and alcohol cleaning wipes. The items contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed. On 05/06/24 at 08:03 AM An inspection of the east hallway's activity area revealed a small, shared corridor outside R12's room. The corridor contained an unsupervised supplemental oxygen storage rack with 10 oxygen cylinders. Three of the ten cylinders were pressured above 1000 pounds per square inch (PSI) and remained accessible in the common area. At 08:15 AM the cylinders and rack were removed from the area. On 05/08/24 at 10:10 AM Certified Nurse's Aide (CNA) M stated the laundry rooms should remain locked and chemicals should never be accessible to the residents. She stated the facility had a secured oxygen storage room for pressurized oxygen tanks. On 05/08/24 at 10:23 AM Licensed Nurse (LN) G stated chemical wipes and hazardous equipment should remain locked up when not in use by staff. She stated staff were expected to closely monitor rooms that were to be locked with hazardous materials in them. On 05/08/24 at 12:20 AM Administrative Nurse D stated the R12's oxygen was moved around by hospice and her representative preferred it to be stored close to her room. She stated the facility has since moved the storage rack and oxygen out of the common area hallway. She stated staff were expected to ensure hazardous chemicals and materials remained locked up and not accessible to the residents. The facility's Incident Reporting and Investigation policy revised 03/2020 indicated staff will ensure the resident environment remains free from potential risk of accidents and falls. The policy noted staff will inspect and report any potential concerns related to fall risks, hazardous materials, and possible injury concerns. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to ensure a safe environment free from hazardous materials and out of reach from nine cognitively impaired independently mobile residents. This deficient practice placed the residents at risk for preventable accidents and injuries. - R15's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), cognitive-communication disorder, dysphagia (difficulty swallowing), and hemiparesis/hemiplegia (weakness and paralysis on one side of the body). R15's Quarterly Minimum Data Set (MDS) completed 04/17/24 indicated a Brief Interview for Mental Status (BIMS) score of four indicating severe cognitive impairment. The MDS indicated he had upper and lower extremity impairments on one side of his body. The MDS indicated he was dependent on staff for transfers, dressing, toileting, bed mobility, and bathing. The MDS indicated he was at risk for pressure injuries (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) and skin breakdown. The MDS indicated he had one non-injury fall since admission. R15's Falls Care Area Assessment (CAA) completed 07/30/23 indicated he was at risk for injuries during transitions related to his medical diagnoses. The CAA noted he required a Hoyer lift (full-body mechanical lift) with the assistance of two staff for all transfers. The CAA indicated he required extensive assistance with toileting, dressing, grooming, mobility, and bathing. R15's Care Plan initiated on 10/18/23 indicated he required staff assistance for bed mobility, toileting, dressing, grooming, personal hygiene, and bathing. The plan indicated he required the assistance of two staff and the use of a Hoyer lift for all transfers. A Resident Incident Report Form completed on 05/03/24 noted R15 received an injury while being transferred with a Hoyer lift. The report indicated R15 was in the Hoyer lift and placed his left hand in between two moving levers of the lift. The report indicated he suffered a quarter-size skin tear on the top of his left hand. The report noted he was immediately assessed by the nurse. The report noted his wound was cleansed and Steri-strips (adhesive wound closures) were applied to his wound. The note indicated staff were to provide frequent reminders and guidance during transfers for proper hand placement. On 05/06/24 at 08:34 AM R15 rested in his bed. R15 had a small skin tear on his left hand secured with three Steri-strips. R15 reported he was not sure how or when the wound occurred. On 05/08/24 at 10:10 AM Certified Nurses Aide (CNA) M indicated R15 required two staff and a Hoyer lift for all transfers due to his limited mobility and fall risk. She stated R15 often would get agitated or anxious during care and move around a lot. She stated staff would talk to him and calm him down before attempting to move him. She stated that R15's hands should be securely on his chest during transfers. She stated the levers on the Hoyer lift are attached to the sling and rotate during transfers. On 05/08/24 at 10:23 AM Licensed Nurse (LN) G stated R15 often got overexcited during care and sometimes moved around a lot. She stated staff should talk to him and ensure he was calm before attempting to move or lift him. She stated the facility required two staff for Hoyer transfers and one of the assisting staff should monitor his hand placement during transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/08/24 at 12:20 AM Administrative Nurse D stated R15's hand injury occurred when he lifted his arms during transfers and his hand got stuck in the moving levers. Administrative Nurse D stated R15 often was anxious and moved around during care. She stated staff were expected to monitor his body placement and behaviors while moving him. She stated his representative comes in to help assist with his anxiety during care and to help him calm down. The facility's Lift, Transfers, and Bed Mobility policy revised 03/2023 indicated the facility will ensure the appropriate personnel as needed, training, and safety for all transfer types. The policy indicated staff will ensure safe positioning and techniques were followed during all assisted transfers. The facility failed to ensure safe Hoyer lift practices were followed during R15's Hoyer transfer resulting in an avoidable accident. This deficient practice placed R15 at risk for preventable accidents and injuries and resulted in a minor injury.

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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. 41713 The facility identified a census of 42 residents. The facility had two medication rooms. Based on observation, record review, and interview, the facility failed to the facility failed to ensure an accurate reconciliation of controlled medications (substances that have an accepted medical use, and have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence) was completed consistently. This placed residents at risk of medication misappropriation, diversion, and ineffective medication regimens. Findings included: - On 05/06/24 at 10:47 AM, observation of the west wing medication room revealed the daily controlled medication record log from 04/20/24 to 05/06/24 lacked evidence of two nurse signatures indicating a reconciliation was completed on 10 of 72 opportunities. On 05/06/24 at 10:50 AM Licensed Nurse (LN) H stated that the count sheet should be signed by the off-going nurse and the on-coming nurse at the beginning and the end of each shift after the narcotic (controlled medications) count had been completed and the medication room keys exchanged. On 05/08/24 at 12:32 PM Administrative Nurse D stated she expected the two nursing staff to be signing the narcotic count shift sheet at the beginning and the end of each shift to indicate the count was completed as required. Administrative Nurse D stated those sign-off sheets were audited two to four times a month by the nurse manager. Administrative Nurse D stated in each of the medication rooms there was a sign posted on the wall to remind staff that the shift narcotic count sheet must be signed off by both staff each shift when the keys for the medication room were exchanged by the off-going to the on-coming nurse. The Narcotics/Controlled Substances policy dated May 2021 documented that narcotic/Controlled substances were counted on a regular basis by the off-going nurse/care associate and the on-coming nurse/care associate. Where permitted by state or local regulations, a licensed nurse and medication technician/registered or certified medication aide may count narcotics/controlled substances. The facility failed to ensure an accurate reconciliation of controlled medications was completed consistently. This placed residents at risk of medication misappropriation, diversion, and ineffective medication regimens.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41713 The facility identified a census of 42 residents. The facility had one main kitchen and one kitchenette area. The facility had two residents that required a pureed diet. Based on observation, record review, and interview, the facility failed to ensure that dietary staff prepared food that conserved the nutritive value, flavor, and appearance when preparing pureed foods. This placed the residents who received pureed foods at risk of decreased palatability and impaired nutritional status. Findings included: - On 05/07/24 at 10:24 AM observation during the preparation of the pureed foods revealed that Dietary Staff (DS) CC obtained two servings of the baked tilapia (fish) and placed them into the Robo coupe (a food processing machine used to finely chop/puree foods) container and then obtained an undetermined amount of water from the faucet and poured the unmeasured amount of water into the pureed container. DS CC turned the machine on until the food and water were mixed. The finished pureed product was poured into a clean metal storage container and covered with plastic wrap. The pureed food item was runny and lacked an attractive appearance or smell. On 05/07/24 at 10:30 AM DS CC obtained two servings of cooked lima beans and placed them in the Robo coupe container. DS CC obtained hot water from the faucet into a pitcher and returned to the Robo coupe and poured an unmeasured amount of water into the Robo coupe container and turned the machine on. DS CC turned the machine off, took off the lid, poured the pureed mixture into a clean metal storage container, and covered it with plastic wrap. The food item had an appearance of a green soup-like consistency. On 05/07/24 at 10:35 AM DS CC obtained two servings of prepared barbecued pulled pork and placed them in the Robo coupe container. DS CC obtained hot water from the faucet into a pitcher and returned to the Robo coupe and poured an unmeasured amount of water into the Robo coupe container and turned the machine on. DS CC turned the machine off, took off the lid, poured the pureed mixture into a clean metal storage container, and covered it with plastic wrap. The pureed barbecued pulled pork after puree had no color to it and did not appear or smell like barbecued pulled pork. On 05/07/24 at 10:39 AM DS CC stated that there used to be puree recipes that he followed but since the new policy was in place, no recipes were used. DS CC stated the new policy was to add water to the original cooked foods until a pudding-thick consistency was obtained. On 05/07/24 at 11:08 AM, DS BB stated the facility had just implemented a new standard operating practice for the preparation of pureed foods and did not require a recipe any longer. On 05/05/24 at 11:39 AM the temperature of the foods on the steam table was obtained by DS EE who was unable to distinguish between the different puree food items of tilapia, French fries, and barbecued pulled pork as the food items lacked labeling. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/24 at 11:14 AM Consultant GG stated the facility recently implemented a new standard operating procedure for food preparation. The new policy and standard of practice had them prepare the food to a pudding consistency and no recipe was followed any longer. Consultant GG stated none of the nutritive value or flavor would be compromised by only adding water to the food. Consultant GG stated the residents who received the pureed food would still receive the same portion and nutrients that residents on a regular diet would receive. The Standard Operating Procedure (SOP) Purees dated December 2023 documented that hot food items would be pureed using food prepared for regular diets. Food would have been cooked to the 'cook to' temperature noted in the recipe and held at a temperature above 140 degrees or greater in the kitchen. Hot food would be pureed following the instructions noted in the recipe. The SOP Texture Modified Diets policy dated January 2024 documented that a recipe should be pureed to a smooth consistency thick enough to mound on the plate and molded or formed to give an attractive plate presentation. If a fortified thickener was used, portion equivalence was to add one ounce to the original portion. Meats and equivalents should add sauces or gravy when possible. The facility failed to ensure that dietary staff prepared food that conserved the nutritive value, flavor, and appearance when preparing pureed foods. This placed the residents who received pureed foods at risk of decreased palatability and impaired nutritional status.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50660 The facility identified a census of 42 residents. The sample included 13 residents. Based on observation, record review, and interviews, the facility failed to provide Resident (R) 28's therapeutic diet as ordered by his physician. This deficient practice placed R28 at risk for complications including choking. Findings included: - R28's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion) and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). R28's Quarterly Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) was unable to be done and no staff interview was completed. The MDS noted that R28 required substantial to maximum assistance from staff for eating. The MDS documented R28 had difficulty or pain with swallowing. R28's Care Plan dated 09/06/23 documented an intervention dated 04/24/24 which directed R28's diet was changed to pureed, with nectar thick liquids. The plan documented R28 required total assistance from staff with eating and directed staff to offer fluids throughout the day. R28's Orders tab under Treatments revealed a dietary order for nectar thick liquids dated 01/11/24. On 05/06/24 at 02:36 PM, an unidentified staff member placed a plastic cup of thin water (not thickened) in R28's room on his dresser. There were no thickened liquids visible in the room. On 05/07/24 at 07:14 AM, observation revealed fresh, thin ice water in a plastic cup in R28's room. There were no thickened liquids visible in R28's room. On 05/07/24 at 09:53 AM observation revealed staff served R28 a pureed breakfast with nectar thick liquids. On 05/07/24 at 02:51 PM observation revealed R28 had nectar thick liquid in a plastic cup, sitting on his dresser. On 05/08/24 at 10:10 AM, Certified Nurse's Aide (CNA) N stated care plans with diet orders were found in the closet in each resident's room and a drawer in the dining room. CNA N said the nurses and CNA passed fresh water each shift and any resident with an order for thickened liquids should never be given thin liquid. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/08/24 at 10:40 AM, Licensed Nurse (LN) I stated that care plans for residents were located in the closet in each resident's room and the hard chart at the nurses' station. LN I reported that R28's diet was pureed with nectar thick liquids. LN I reported she witnessed the incorrect consistency of fluids in R28's room on previous occasions and she thought it was placed there by the night shift. LN I stated that if R28 received thin liquids he could suffer potential consequences such as aspiration pneumonia (an inflammatory condition of the lungs caused by inhaling foreign material or vomit). In an interview on 05/08/24 at 11:30 AM Administrative Nurse D stated that R28 should never be given thin liquids. She said the nursing staff has had education regarding the risks and benefits of diet and liquid consistency. The facility's Thickened Liquids policy revised 03/2020 indicated the facility will provide thickened liquids when ordered. The policy indicated thickener was used to promote ease of swallowing. The policy also indicated the thickener was used to prevent choking and aspiration. The facility failed to provide R28's therapeutic diet as ordered by his physician. This deficient practice placed R28 at risk for complications including choking.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41713 The facility identified a census of 42 residents. The facility had one main kitchen and one kitchenette and dining area. Based on observation and interview, the facility failed to ensure staff stored, prepared and served food items and maintained the freezer unit in accordance with the professional standards for food service safety. This placed residents at risk of foodborne illness and cross-contamination (the transfer of harmful substances to food). Findings included: - On 05/06/24 at 07:12 AM the initial tour of the kitchen revealed the following: in the walk-in freezer there was an opened box and bag of breaded chicken strips that was not in a sealed bag and lacked an open date. The walk-in freezer unit had frozen water icicles that had dropped onto an opened box of food below it. On 05/07/24 at 10:24 AM during the preparation of the puree foods, Dietary Staff CC failed to properly wash and sanitize the Robo coupe (a food processing machine used to puree foods) container and lid in between each food item that was pureed. On 05/08/24 at 10:48 AM Dietary Staff EE stated that he expected his staff to either run the food containers through the dishwasher or wash and sanitize in the three-bin wash sinks. Dietary EE stated he had not been aware that the freezer unit was leaking and would get that matter addressed. The Standard Operating Procedure (SOP) Food Preparation and Service policy dated February 2024 documented: strict food preparation procedures were maintained to assure consistent high-quality food service. Sinks, slicing machines, and cutting boards must be cleaned and sanitized after each use before handling other food. The facility failed to ensure staff stored, prepared and served food items and maintained the freezer unit in accordance with the professional standards for food service safety. This placed residents at risk of foodborne illness and cross-contamination.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45668 The facility identified a census of 42 residents. The sample included 13 residents. Based on record review, observations, and interviews, the facility failed to ensure infection control standards were followed during shared equipment use, transport of clean linens, and storage of Resident (R)12's oxygen therapy equipment. This deficient practice placed the residents at risk for infectious diseases. Findings Included: - On 05/06/24 at 07:15 AM an inspection of R12's bathroom revealed her supplemental oxygen face mask and two oxygen connector ports stored on a paper towel on a shared sink. On 05/07/24 at 08:44 AM, an unidentified nurse completed blood pressure checks for R29 and R136. The nurse failed to sanitize the shared blood pressure equipment in between taking the residents' vitals. On 05/07/24 at 09:49 AM staff pushed the Hoyer (total body mechanical lift) lift into R28's room. Staff then transferred R28 from his bed to his wheelchair. The Hoyer lift was then pushed by staff back out to the hallway without sanitizing the machine before or after use. On 05/07/24 at 02:24 PM a large, uncovered cart carrying brown towels was transported through the facility's east hall. On 05/08/24 at 10:10 AM Certified Nurse's Aide (CNA) M stated staff can wash residents' clothing and items in the small laundry rooms. She stated all laundry should be covered in transport. She stated lifts and other shared equipment should be cleaned and sanitized in between uses. She stated oxygen tubing and masks should be stored in a clean bag when not in use. On 05/08/24 at 10:23 AM Licensed Nurse (LN) G stated oxygen mask and tubing should always be labeled. She stated the mask and tubing should be placed in a clean bag for storage when not in use. She stated staff should cover the laundry baskets and carts when transporting them around the facility. She stated that shared lifts and equipment should be sanitized in between use. On 05/08/24 at 12:20 PM Administrative Nurse D stated staff were expected to store the oxygen equipment in the provided clean bags. She stated R12's oxygen mask may have been cleaned by staff and left out to dry until it could be stored in a bag. She stated staff was expected to clean all shared equipment in between uses. The facility's Infection Prevention and Control Surveillance and Monitoring policy revised 05/2021 indicated the facility will implement and ensure safe infection control practices related to the sanitary handling and storage of medical equipment, medications, and care practices to prevent contamination and infections. The policy indicated staff will ensure the sanitary handling of oxygen therapy equipment, medications, care environments, and contact precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175541	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tallgrass Creek, Inc	13760 Metcalf Avenue Overland Park, KS 66223

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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 - Some	The facility failed to ensure infection control standards were followed during shared equipment, transport of linens, and storage of R12's oxygen therapy equipment. This deficient practice placed the residents at risk for infectious diseases.