STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185242	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Care Center	125 Sterling Way Mount Sterling, KY 40353

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44000 Based on observation, interview, record review, and review of the facility's policies, the facility failed to develop and/or implement a Comprehensive Care Plan (CCP) to ensure it met the residents' medical, nursing, mental, and psychosocial needs as identified on his/her comprehensive assessment and other assessments for 2 of 26 sampled residents, Resident (R) 30 and R31. Review of R30's Comprehensive Care Plan [CCP] revealed staff failed to follow the interventions based on the physician's orders for the administration of oxygen. Review of R31's CCP revealed the facility failed to develop a care plan for R31's dialysis catheter. The findings include: Review of the facility's Comprehensive Care Plans policy, not dated, revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Further review revealed the facility would notify qualified staff responsible for implementing the care plan when interventions were added to the care plan or when changes were made. Review of the facility's policy titled, Oxygen Administration, not dated, revealed oxygen was to be administered under orders of a physician, except in the case of an emergency. In such case, oxygen was administered and orders for oxygen were obtained as soon as practicable when the situation was under control. 1. Review of R31's Admission Record revealed the facility admitted R31 on 08/02/2018 with diagnoses to include end stage renal disease (ESRD), heart failure, and diabetes. Review of R31's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 12/31/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 14 out of 15, indicating intact cognition. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R31's CCP, last reviewed 02/20/2025, revealed R31 did not have a plan on how to care for his dialysis catheter. During interview with R31 on 03/11/2025 at 10:35 AM, he stated he was on dialysis. He further stated he had a port in the right upper chest. R31 also stated it was supposed to be removed the 10th of next month. Observation at the time of the interview revealed a dialysis catheter was sutured into his upper right chest with two lines from the port. The site had approximately 1.5 inch of redness surrounding the port. There was approximately 0.25 inch of dried blood where the catheter entered the skin. During interview with Registered Nurse (RN) 1 on 03/11/2025 at 10:46 AM, she stated R31 had a port, and it was to be removed on 04/10/2025. She further stated staff was just monitoring for infection. She stated staff was not accessing or doing anything with the port. During interview with the Director of Nursing (DON), on 03/13/2025 at 10:55 AM, she stated she expected staff to develop care plans for dialysis catheters. She further stated dialysis catheters needed to be monitored to make sure there was no drainage. 50442 2. Review of R30's Admission Record revealed the facility admitted R30 on 10/07/2021 with diagnoses of acute on chronic diastolic heart failure, chronic respiratory failure with hypercapnia, and chronic obstructive pulmonary disease (COPD). Review of R30's quarterly MDS, with an ARD of 02/17/2025, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, indicating intact cognition. Further review revealed the resident was assessed as needing continuous oxygen therapy. Review of R30's Physician's Orders, dated 12/04/2024, revealed orders for oxygen at four (4) Liters (L) per minute per nasal cannula (NC) continuously. Review of R30's CCP, dated 03/18/2023, revealed R30 had oxygen therapy related to respiratory illness as a focus. The goal of the focus was that R30 would have no signs and symptoms of poor oxygen absorption through the review date of 05/18/2025. One intervention for the care plan focus area was oxygen would be administered at 4 L per minute via nasal cannula. Observation on 03/11/2025 at 9:32 AM revealed R30's oxygen concentrator was set on 5 Liters (L) per minute per nasal cannula (NC), and on 03/12/2025 at 11:59 AM, R30's oxygen concentrator was set on 4.5 L per minute per NC. During interview with Family Member (F) 5 on 03/12/2025 at 11:59 AM, he stated R30 was continuously sent out to the hospital for her oxygen due to exacerbation of her COPD and heart failure. He stated the hospital would fix R30's oxygen level overnight and send her back to the facility. He stated then, it would happen all over again. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 03/12/2025 at 1:44 PM with Kentucky Medication Aide (KMA) 1, she stated R30 wore her oxygen but would not wear her bipap (a device that delivered a continuous positive airway pressure for inhalation and exhalation). KMA1 stated, when R30's oxygen saturation level got low, she would wear the bipap until her carbon dioxide levels decreased, and she became more alert. She stated, however, then R30 would remove the bipap again. During interview with Licensed Practical Nurse (LPN) 1 on 03/12/2025 at 2:35 PM, she stated R30 would wear her oxygen administered by a nasal cannula but would often pull it out of her nose. She stated R30's multiple hospitalization s stemmed from her chronic heart failure (CHF) and COPD exacerbations due to improper oxygenation. She stated she made sure the oxygen concentrator matched R30's orders each shift. She stated if it was not set at the right level (too high) this would increase R30's carbon dioxide levels, and residents like R30 often would say they were short of breath or they would become lethargic. LPN1 stated if the concentrator was set on the wrong amount, she would check the resident's oxygen saturation and change the concentrator back to correct setting. During interview with Unit Manager/RN1 on 03/12/2025 at 1:59 PM, she stated R30 would wear her oxygen provided by her nasal cannula and refused to wear her bipap. RN1 stated staff should check the oxygen concentrator settings and compare it to the order and care plan each shift. She stated if a resident was not on the appropriate administration rate for oxygen as specified in the orders and care plan, she would correct and find out why the concentrator was set higher/lower. She stated if the oxygen administration rate was set higher than ordered, R30's carbon dioxide went up, and she became lethargic and confused. She stated R30 had multiple hospitalization s due to refusing to wear her bipap and having hypercapnia (high carbon dioxide levels) and hypoxia (low oxygen levels). During interview with the DON on 03/13/2025 at 8:18 AM, she stated it was her expectation that staff checked the oxygen orders and the resident's care plan against the oxygen concentrator settings a minimum of each shift. She stated she hoped staff glanced at the concentrator each time they entered a resident's room. The DON stated administration of too much oxygen to a resident with COPD (like R30) caused carbon dioxide to build up which caused hypoxia. She stated she expected staff to follow the CCP for each resident. During interview with the Administrator on 03/13/2025 at 8:35 AM, he stated staff should check the oxygen concentrator each time they went into a resident's room or at a minimum each shift. He stated there could be a problem with too much oxygen being administered to a resident by causing hypercapnia in a resident with COPD. He stated staff should follow the CCPs.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 50442 Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure residents requiring respiratory care were provided such care consistent with professional standards of practice for 1 out of 3 residents sampled for respiratory care, Resident (R) 30. Observation on 03/11/2025 at 9:32 AM revealed R30's oxygen concentrator was set on 5 Liters (L) per minute via nasal cannula (NC), and on 03/12/2025 at 11:59 AM, R30's oxygen concentrator was set on 4.5 L per minute via NC. However, review of R30's Physician's Orders revealed R30 had orders for oxygen to be administrated continuously at 4 L per minute via NC. The findings include: Review of the facility's policy titled, Oxygen Administration, not dated, revealed oxygen was to be administered under orders of a physician, except in the case of an emergency. In such case, oxygen was administered and orders for oxygen were obtained as soon as practicable when the situation was under control. Review of R30's electronic medical record (EMR) Admission Record revealed the facility admitted R30 on 10/07/2021 with diagnoses of acute on chronic diastolic heart failure, chronic respiratory failure with hypercapnia, and chronic obstructive pulmonary disease (COPD). Review of R30's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 02/17/2025, revealed the facility assessed R30 to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, indicating intact cognition. Further review revealed the resident was assessed as needing continuous oxygen therapy. Review of R30's Physician's Orders, dated 12/04/2024, revealed orders for oxygen at four (4) Liters (L) per minute per nasal cannula (NC) continuously. Review of R30's Comprehensive Care Plan [CCP], dated 03/18/2023, revealed R30 had oxygen therapy related to respiratory illness as a focus. The goal of the focus was that R30 would have no signs and symptoms of poor oxygen absorption through the review date of 05/18/2025. One intervention for the care plan focus area was oxygen would be administered at 4 L per minute via NC. Observation on 03/11/2025 at 9:32 AM revealed R30's oxygen concentrator was set on 5 Liters (L) per minute via NC, and on 03/12/2025 at 11:59 AM, R30's oxygen concentrator was set on 4.5 L per minute per NC. The State Survey Agency (SSA) Surveyor was unable to observe R30's oxygen concentrator on 03/13/2025 because R30 was hospitalized for low oxygen saturations on the evening of 03/12/2025. In an interview with Family Member (F) 5 on 03/12/2025 at 7:47 PM, he stated R30 was continuously sent out to the hospital for her oxygen issues (exacerbation of her COPD and heart failure), and the hospital would fix her overnight and send her back to the facility. F5 stated it would then happen again. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/12/2025 at 1:44 PM with Kentucky Medication Aide (KMA) 1, she stated R30 wore her oxygen but would not wear her bipap (a device that delivered a continuous positive airway pressure for inhalation and exhalation). KMA1 stated, when R30's oxygen saturation level got low, she would wear the bipap until her carbon dioxide levels diminished, and she became more alert. However, then she would remove the bipap. In an interview with Licensed Practical Nurse (LPN) 1 on 03/12/2025 at 2:35 PM, she stated R30 would wear her oxygen administered by a nasal cannula but would often pull it out of her nose. LPN1 stated she had even found R30 with it on her forehead. She stated she would put the oxygen back on correctly and educate R30 that her oxygen levels would drop if she continued to take off her oxygen. LPN1 stated R30 refused to wear the bipap. She stated most nights R30 would only wear the bipap for a maximum of two to three hours if at all. She stated when R30's carbon dioxide levels went up, R30 became lethargic, and staff would then be able to put on the bipap to help get rid of the increased carbon dioxide. She stated when R30 roused up, she would take the bipap back off. LPN1 stated R30's multiple hospitalization s stemmed from her chronic congestive heart failure (CHF) and COPD exacerbations due to improper oxygenation. LPN1 stated she made sure the oxygen concentrator matched R30's orders each shift. She stated if the oxygen concentrator was not set at the right level (too high) this would increase R30's carbon dioxide levels, and residents like R30 often would say they were short of breath or they would become lethargic. LPN1 stated if the concentrator was set on the wrong amount of oxygen delivered, she would check the resident's oxygen saturation and change the concentrator back to the correct setting. In an interview with Unit Manager/Registered Nurse (RN) 1 on 03/12/2025 at 1:59 PM, she stated R30 would wear her oxygen provided by her nasal cannula, but refused to wear her bipap. RN1 stated staff should check the oxygen concentrator settings and compare it to the order each shift. RN1 stated if a resident was not on the appropriate administration rate for oxygen as specified in the orders, she would correct and find out why the concentrator was set higher/lower. She stated if the oxygen administration rate was set higher than ordered, R30's carbon dioxide increased, and she became lethargic and confused. She stated R30 had multiple hospitalization s due to refusing to wear her bipap and having hypercapnia and hypoxia. RN1 stated she tried to teach and instruct R30 on the importance of wearing her bipap, but R30 still refused to wear it. In an interview with the Medical Director on 03/12/2025 at 6:46 PM, he stated it was his expectation that staff followed his orders for oxygen administration. He stated R30 should wear her oxygen continuously, delivered through her NC, while she was awake and her bipap while she was sleeping. He stated if R30's oxygen saturations fell , it was OK for the nurse to increase the oxygen up to 5 L per minute, but once R30 was stabilized, the nurse should call him and have the order changed. In an interview with the Director of Nursing (DON) on 03/13/2025 at 8:18 AM, she stated it was her expectation that staff checked the oxygen orders against the oxygen concentrator settings at a minimum of each shift. She stated she hoped staff glanced at the concentrator settings each time they entered a resident's room. The DON stated administration of too much oxygen to a resident with COPD (like R30) caused carbon dioxide to build up which caused hypoxia. She stated she expected staff to follow the Physician's Orders and the CCP for each resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 03/13/2025 at 8:35 AM, he stated staff should check the oxygen concentrator each time they went into a resident's room or at a minimum each shift. He stated there could be a problem with too much oxygen being administered to a resident with COPD because the resident could experience hypercapnia. He stated staff should follow the Physician's Orders and the CCPs.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 51155 Based on observation, interview, review of the facility's documents, and review of the facility's plan of correction (PoC), dated 05/27/2024, the facility failed to have an effective Quality Assurance Performance Improvement (QAPI) process. The facility failed to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focused on indicators of the outcomes of care and quality of life that were achieved and sustained for 1 of 50 sampled residents, Resident (R) 325. Observation on 03/12/2025 at 9:21 AM revealed State Registered Nurse Aide (SRNA) 8 and SRNA7 entered R325's room, who was on droplet precautions, performed resident care, then exited the room with a used, uncleaned gait belt placed in SRNA7's pant pocket. Review of the previous survey, dated 04/30/2024 to 05/03/2024, revealed a repeat issue was found with equipment not being cleaned between resident use. Refer to F880 The findings include: Review of the facility's acceptable PoC, for the Standard Recertification/Abbreviated/Extended Survey, concluded on 05/03/2024, revealed the facility was to implement the PoC to ensure the facility achieved substantial compliance by 06/12/2024. However, the facility had a repeat deficiency following the latest survey, concluded on 03/13/2025. Further review of the facility's PoC, for the survey with an exit date of 05/03/2024, revealed the Director of Nursing (DON) visually monitored two different employees per day to confirm equipment cleaning between residents. Furthermore, the PoC stated these observations would be completed three times per week for four weeks then monthly for two months. Review of the facility's Plan of Correction Monitoring Tool revealed the facility would perform weekly audits for two employees, three times per week for four weeks then weekly for two months. The review of audits performed by the Director of Nursing (DON) revealed audits were completed as directed by the PoC from 06/04/2024 to 08/28/2024. Review of the facility's Staff In-Service Attendance Record discussing cleaning and disinfecting shared equipment was dated 05/09/2024, 05/10/2024, 05/17/2024, 05/24/2024, and 05/29/2024. Observation on 03/12/2025 at 9:21 AM revealed SRNA8 and SRNA7 entered R325's room, who was on droplet precautions, performed resident care, then exited the room with a used, uncleaned gait belt placed in SRNA7's pant pocket. During an interview on 03/12/2025 at 9:21 AM with SRNA8, she stated she had used the gait belt while in the resident's room and was going to clean it with sani-wipes (a disinfectant wipe) that were at the nurses' station. She stated that once the gait belt was cleaned, she placed it back into her pocket. SRNA8 stated it was important to clean and store dirty/clean shared equipment properly to stop the spread of infection. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/2025 at 9:21 AM with SRNA7, she stated she kept her gait belt around her waist, and it was important not to place a dirty shared equipment and a clean shared equipment in the same place to prevent the spread of infection. During an interview on 03/12/2025 at 10:05 AM with the Infection Prevention (IP) Nurse, she stated we've done a lot of verbal and hands on education regarding cleaning shared equipment because the facility went through this on the last survey. She stated SRNAs were expected to keep gait belts on them, and they were expected to clean them with sani-wipes after each use. She stated that was important so infections were not transmitted from one person to another. During an interview on 03/13/2025 at 10:45 AM with the Director of Nursing (DON), she stated audits related to F880, from the last survey, were performed for at least three months. She stated she no longer performed audits of cleaning shared equipment and hand hygiene. She stated it was her expectation that staff follow policies and procedures to keep infections down. She stated it was her expectation that all the appropriate people attended QAPI meetings for QAPI to be successful. During an interview on 03/13/2025 at 4:23 PM with the Administrator, he stated quality assurance meetings were held every day. He stated during those meetings, if a process was not successful, then adjustments were made to improve it. The Administrator stated he maintained oversight of QAPI. He stated shared equipment should be cleaned and disinfected to prevent infection and any kind of 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50442 Based on observation, interview, record review, and review of the facility's policies, the facility failed to establish or maintain an effective infection prevention and control program, which was essential for providing a safe, sanitary, and comfortable environment while preventing the development and spread of infectious diseases for 5 of 50 sampled residents, Resident (R) 30, R17, R74, F90, and R325. 1. Observation on 03/11/2025 and 03/12/2025 revealed R30's oxygen nasal cannula tubing was dated 02/18/2025, and the humidification water bottle was undated. 2. Observation on 03/11/2025 revealed State Registered Nurse Aide (SRNA) 3 and SRNA5 were seen not hand sanitizing between passing lunch trays for R17, R74, and R90. Further observation on 03/12/2025 revealed SRNA13 touched R90's food with no gloves on and hand hygiene not performed. 3. Observation on 03/12/2025 revealed SRNA8 and SRNA7 entered R325's room, who was on droplet precautions, performed resident care, then exited the room with the used, uncleaned gait belt, and SRNA7 put it in her pant pocket. 4. Observation on 03/12/2025 of R30's wound care revealed Licensed Practical Nurse (LPN) 1 did not sanitize hands between changing gloves. 5. Observation on 03/13/2025 at 9:45 AM of laundry services revealed gowns were not worn in the laundry while staff handled dirty or soiled linens. The findings include: Review of the facility's policy titled, Hand Hygiene, not dated, revealed all staff would perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applied to all staff working in all locations within the facility. Per the policy's attachment, hand hygiene via either with soap and water or with alcohol based hand rub should be performed before and after applying personal protective equipment (PPE) such as gloves, before and after handling clean or soiled dressings, linens, etc., and during resident care when moving from a contaminated body site to a clean body site. Additional review revealed the use of gloves did not replace hand hygiene, and if the task required gloves, perform hand hygiene prior to donning (putting on) gloves and immediately after removing gloves. Review of the facility's policy titled, Oxygen Administration, revealed staff should change tubing weekly and as needed if it became soiled or contaminated for infection prevention purposes. Review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Equipment, undated, revealed resident care equipment can be a source of indirect transmission of pathogens. The policy also stated that each user is responsible for routine cleaning and disinfection of multi resident items after each use, particularly before use for another resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Personal Protective Equipment [PPE], undated, revealed, This facility promotes appropriate use of personal protective equipment to prevent the transmission of pathogens to residents, visitors, and other staff. The policy also stated, All staff who have contact with resident and/or their environments must wear PPE equipment as appropriate during resident care and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely. Review of the facility's policy titled, Laundry, undated, revealed staff shall consider all previously worn clothing and used linens as potentially contaminated, and laundry staff will be in-serviced to handling linens and laundry on a regular basis. 1. Observation of R30 on 03/11/2025 at 9:32 AM and 03/12/2025 at 11:59 AM revealed she had on oxygen being administered via nasal cannula. Further observation of R30's oxygen concentrator revealed it was hooked to a humidification bottle that was full of water. There was no date on the bottle. The oxygen tubing was dated 02/18/2025. Observation could not be done on 03/13/2025 because R30 was hospitalized on [DATE]. Review of R30's Treatment Administration Record revealed that in January 2025 and February 2025 oxygen tubing was changed weekly on Tuesdays, except for 02/18/2025, which was not marked off. Review of the month of March had both Tuesdays marked for the changing of the tubing. In an interview on 03/12/2025 at 2:35 PM with LPN1, she stated oxygen tubing and the humidification water bottle for administration of oxygen via nasal cannula were changed weekly, on Tuesday evenings. She stated both should be dated the date they were changed. She stated they should be changed to prevent infections. In an interview on 03/13/2025 at 8:11 AM with the Infection Prevention (IP) Nurse, she stated oxygen tubing was changed weekly, and the humidification bottles should be changed when empty or when the oxygen tubing to administer oxygen via nasal cannula was changed. She stated both were to be labeled with the date they were changed. The IP Nurse stated oxygen tubing that was not changed was a source of infection because of bacterial growth. In an interview on 03/13/2025 at 8:18 AM with the Director of Nursing (DON), she stated oxygen tubing and the humidification water bottle should be changed weekly. She stated some individuals that were on continuous high levels of oxygen might need their humidification water bottle changed more frequently, as it might run dry more frequently. She stated that an issue that could result from oxygen tubing dated 2/18/2025 observed on 03/12/2025 and 03/13/2025 still in use would be the user could get a respiratory infection. In an interview on 03/13/2025 at 8:35 AM with the Administrator, he stated oxygen tubing and humidification water bottles needed to be changed weekly or if soiled. He stated both should be dated when changed. He stated an issue that could result from oxygen tubing being used longer than a week could be an infection. 2. On 03/11/2025 at 12:23 PM during observation of the lunch service, two State Registered Nurse Aides (SRNA) 3 and SRNA5, were seen not hand sanitizing between distributing trays for R17, R74, and R90. Further observation on 03/12/2025 at 12:22 PM revealed SRNA13 touched R90's food with no gloves on and hand hygiene not performed. (continued on next page)

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Windsor Care Center	125 Sterling Way Mount Sterling, KY 40353

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	In interviews with both SRNA3 and SRNA5 on 03/11/2025 at 12:40 PM and 12:35 PM respectively, both stated hand hygiene should be performed between each delivered tray, either using alcohol-based hand gel or washing hands with soap and water. In an interview on 03/13/2025 at 8:11 AM with the IP Nurse, she stated staff should hand sanitize between each tray with the alcohol-based hand gel and wash their hands with soap and water after every third tray delivered. She stated if a resident's food was touched, the staff member should wear gloves. In an interview on 03/13/2025 at 8:18 AM with the DON, she stated staff should hand sanitize between each resident's tray with alcohol-based hand gel and wash their hands with soap and water after every third tray delivered or when soiled. In an interview on 03/13/2025 at 8:35 AM with the Administrator, he stated his expectation was that staff should keep their hands clean and not touch the food when distributing meal trays to the residents. He stated if a staff member needed to touch a resident's food, they should wear gloves. He stated hand hygiene should be performed between each tray and when visibly soiled. 3. Observation on 03/12/2025 at 9:21 AM revealed SRNA8 and SRNA7 entered R325's room, who was on droplet precautions, performed resident care, then exited the room with the used, uncleaned gait belt placed in SRNA7's pant pocket. Review of R325's Admission Record revealed the facility admitted R325 on 03/11/2025 with a diagnosis of influenza. Review of the facility's list of Residents on Isolation Precautions, provided by the facility, listed 19 residents, including R325, who was on Droplet Precautions for influenza. During an interview on 03/11/2025 at 12:13 PM with SRNA3, she stated she carried her gait belt around her waist, and each SRNA had their own. She stated she did not clean her gait belt between each resident use. During an interview on 03/11/2025 at 12:15 PM with SRNA4, she stated she had her own gait belt, and she washed it at her house after her shifts. She stated during her shift, between resident use, she used an antibacterial spray provided by the janitor. She stated gait belts were part of their uniform, and they must keep them on person while working. During an interview on 03/11/2025 at 12:17 PM with SRNA5, she stated she sanitized her gait belt with sani-wipes (a disinfectant) between each use. She stated the wipes were kept at the nurses' stations, and it was important not to spread germs. During an interview on 03/12/2025 at 9:21 AM with SRNA8, she stated she had used her gait belt on R325 while in the room and placed it in her pocket when she was finished using it, prior to cleaning it. She stated she was going to clean it with sani-wipes that were at the nurses' station. She stated once she cleaned it, she usually placed it back into her pocket. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/12/2025 at 9:21 AM with SRNA7, she stated she kept her gait belt around her waist, and it was important not to place a dirty shared equipment and a clean shared equipment in the same place to prevent the spread of infection. During an interview on 03/12/2025 at 10:05 AM with the IP Nurse, she stated we've done a lot of verbal and hands on education regarding cleaning shared equipment because the facility had gone through this on the last survey. She stated SRNAs were expected to keep gait belts on them, and they were expected to clean them with sani-wipes after each use. She stated this was important so infections were not transmitted from one person to another. 4. Observation on 03/12/2025 at 12:05 PM of R30's wound care performed by LPN1 revealed she hand sanitized and put on gloves prior to cleaning R30's pressure ulcer with normal saline. LPN1 then removed her gloves and placed on a new pair without performing hand hygiene. She rubbed the zinc cream onto R30's pressure ulcer with her gloved hand and then removed the gloves. Once again, she did not perform hand hygiene prior to placing on a new pair of gloves. Instead, she began to rub the zinc cream on various open sores on R30's hip, abdomen, and shoulder without changing gloves between sites and without washing her hands. In an interview with LPN1 on 03/12/2025 at 12:23 PM, she stated hand hygiene should be done prior to, during, and throughout wound care. When asked if hand hygiene should be performed between each glove change, LPN1 stated yes. LPN1 stated she should have used hand sanitizer each time she changed her gloves, but there was not any in the room, so she did not. LPN1 stated she should have changed gloves when placing zinc cream on different parts of R30's body to prevent contamination of the wounds. In an interview with Unit Manager/Registered Nurse (RN) 1 on 03/12/2025 at 1:59 PM, she stated staff should hand sanitize and change gloves before and after resident care. In an interview on 03/13/2025 at 8:11 AM with the IP Nurse, she stated it was her expectation that staff hand sanitized or washed their hands before and after putting on or taking off gloves. In an interview on 03/13/2025 at 8:18 AM with the DON, she stated her expectation was that hands should be washed or alcohol-based hand gel should be used every time a staff member changed gloves, in addition to prior to and after resident care. In an interview on 03/13/2025 at 8:35 AM with the Administrator, he stated hand hygiene should be performed between glove changes. 51155 5. Observation on 03/13/2025 at 9:45 AM of laundry services revealed gowns were not worn while handling dirty or soiled linens. During an interview on 03/12/2025 at 9:45 AM with the Environmental Supervisor, he stated exam gloves were used while handling dirty laundry, but gowns were only used for laundry from COVID rooms. He stated gowns were not worn otherwise. He stated he did not know what the facility policy stated regarding PPE and dirty linens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/12/2025 at 9:45 AM with the Laundry and Housekeeping Supervisor, she stated only gloves were worn when handling soiled/dirty laundry, and gowns were only worn when linens were from a COVID positive room. She stated she was not aware of what the facility policy stated regarding PPE and dirty linens. During an interview on 03/13/2025 at 10:45 AM with the DON, she stated it was her expectation that staff follow policies and procedure to keep infections down. During an interview on 03/13/2025 at 4:23 PM with the Administrator, he stated his expectation was that staff properly cleaned shared equipment between resident use to prevent infection and any kind of cross contamination.