STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185309	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring View Nursing & Rehabilitation	718 Goodwin Lane Leitchfield, KY 42754

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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the facility's investigations, documentation, and policy, the facility failed to ensure its licensed staffs' competencies included active Cardiopulmonary Resuscitation (CPR) certifications for 11 of 11 licensed nursing staffs' personnel files reviewed. On [DATE], staff found R71 unresponsive and without pulse or respirations. R71 had a Full Code status; however, staff failed to attempt and provide lifesaving measures. Immediate Jeopardy (IJ) was identified on [DATE]. The Administrator was provided a copy of the CMS Immediate Jeopardy Template on [DATE] at 11:32 AM and notified the facility's failure to ensure its licensed staffs' CPR certifications were current was likely to cause serious injury, impairment, or death and constituted IJ. IJ was identified at 42 CFR S483.35 Nursing Services, F726, and determined to exist on [DATE], at a highest Scope and Severity (S/S) of L. The facility provided an acceptable IJ Removal Plan on [DATE]. The plan alleged removal of the IJ, and the deficient as of [DATE]. An Extended and IJ Removal Validation Survey was conducted on [DATE], and the State Survey Agency (SSA) validated the facility's IJ Removal Plan on [DATE]. The SSA validated the immediacy of the IJ as removed on [DATE], as alleged. (Refer to F678)The findings include: Review of the facility's policy titled, Cardiopulmonary Resuscitation (CPR), revised [DATE], revealed the facility was to adhere to residents' rights to formulate advance directives. Per review, the facility would also implement guidelines regarding CPR including CPR certified staff to always be available. Further review revealed staff were to maintain current CPR certifications for healthcare providers through a CPR provider who evaluated proper technique through in-person demonstration of skills. Review of the facility's Registered Nurse (RN), and Licensed Practical Nurse (LPN) Job Descriptions updated [DATE], revealed they must have a current/active CPR certification. Review of the Certified Nurse Aide (CNA) job description dated 12/2018, revealed a current/active CPR certification was preferred for CNAs. Review of R71's Face Sheet revealed the facility admitted the resident on [DATE], with diagnoses of transient ischemic attack (TIA/stroke), cerebral infarction without residual deficits, old myocardial infarction. Further record review revealed the facility discharged R71 due to her death in the facility on [DATE]. Review of the Advanced Directives Comprehensive Care Plan for R71, initiated on [DATE] and revised on [DATE], revealed the resident had a Full Code Status. Further review revealed the interventions included to administer CPR if the resident was found without pulse or respirations. Review of the Kentucky Living Will Directive for R71, dated [DATE], revealed it had been signed by the resident, and the resident's wishes were for life-prolonging treatment not to be withheld or (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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	withdrawn. Review of a physician's order, dated [DATE], revealed R71's Code Status was noted as Full Code. Review of the progress note, documented by Licensed Practical Nurse 1 (LPN1), dated [DATE] at 3:15 AM, revealed the nurse had been called to R71's room. Per review, the LPN found the resident with no pulse, respirations, or signs of life. LPN1 did not initiate CPR. Review of 11 out of 11 licensed staffs' personnel records reviewed revealed their CPR certifications were not up to date. The licensed staff included: Registered Nurse (RN) R1, RN2, the Director of Nursing (DON); Licensed Practical Nurse (LPN) LPN1, LPN2, LPN4, LPN6, LPN7, LPN8, LPN9 and LPN10. 1) RN 1 received her CPR certification on [DATE]. 2) RN 2 received her CPR certification on [DATE]. 3) The DON received her CPR certification on [DATE]. 4) LPN 1 received her CPR certification on [DATE]. 5) LPN 4 received her CPR certification on [DATE]. 6) LPN 10 received her CPR certification on [DATE]. 7) LPN 6 received her CPR certification on [DATE]. 8) LPN 7 received her CPR certification on [DATE]. 9) LPN 2 received her CPR certification on [DATE]. 10) LPN 8 received her CPR certification on [DATE]. 11) LPN 9 received her CPR certification on [DATE]. Additional record reviews revealed no documented evidence of prior CPR certifications for the above licensed staff. In interview on [DATE] at 7:45 PM, Licensed Practical Nurse (LPN) stated she received CPR training in [DATE]. However, she stated she could not recall if she had an active CPR certification at the time of R71's death ([DATE]). In interview on [DATE] at 4:25 PM, the Director of Nursing (DON) stated she had been the former Assistant Director of Nursing (ADON) at the time of R71's death. She stated she had been working the evening shift on [DATE]. She further stated she did not initiate CPR due to R71's condition; however, typically a resident with a full code status should have had CPR initiated. In addition, the DON stated she started at the facility about a year ago and was not certified in CPR until [DATE]. In interview on [DATE] at 4:14 PM, the Staff Development Coordinator (SDC) stated she was responsible to ensure staff were CPR certified. She stated most of the nurses should be CPR (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	certified; however, there might be a couple whose CPR had expired, and she had been working on that. Additionally, she further stated she expected staff to follow the facility's policy and orders when CPR was to be performed. In an interview on [DATE] at 9:25 AM, the Staff Development Coordinator stated, When I started this position 4-5 years ago, the Administrator told me it was not required for licensed staff to have an active CPR certification. She stated she had not questioned the Administrator when he told her it was not required, and she did not question it any further. She stated it was in the facility's job descriptions for licensed and certified staff to be CPR certified, and she knew they were supposed to have that certification. In interview on [DATE] at 4:48 PM, the Administrator stated he expected the facility to have proper monitoring of which staff were certified in CPR. He stated that was a responsibility as a licensed nurse. The Administrator stated he had instructed the SDC that the facility should have licensed and certified staff active in their CPR certifications. However, a certified Nurse Aide (CNA) was preferred to have CPR, but it was not a requirement. The Administrator stated there should have been better communication about the requirements of CPR certifications among the staff. He stated knowing if staffs' CPR certifications were active or not was not something he personally tracked on his own; however, it was also a requirement of the facility. In addition, the Administrator stated he should have been overseeing staffs' CPR certifications, and he would be doing that going forward.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the facility's policy, the facility failed to ensure the physician was immediately notified of a significant change in a resident's status for 1 of 40 sampled residents, (Resident (R)71). R71 who was full code expired at the facility. Staff failed to initiate CPR and failed to immediately notify the physician.Immediate Jeopardy (IJ) was identified on [DATE]. The Administrator was provided a copy of the CMS Immediate Jeopardy (IJ) Template on [DATE] at 11:32 AM and notified that the facility's failure to ensure immediate physician notification of a change was made was likely to cause serious injury, impairment, or death and constituted IJ. IJ was identified at 42 CFR S483.210, Notify of Changes, F580, and was determined to exist on [DATE], at a highest Scope and Severity (S/S) of J. The facility provided an acceptable IJ Removal Plan on [DATE]. The plan alleged the IJ was removed on [DATE]. An Extended and IJ Removal Validation Survey was conducted on [DATE]. The State Survey Agency (SSA) validated the facility's IJ Removal Plan on [DATE]. The SSA validated the immediacy of the IJ had been removed on [DATE], as alleged. The findings include: Review of the facility's policy titled, Notification of Changes, reviewed 02/2025, revealed the facility would promptly inform the resident, consult the resident's physician, and notify the resident's representative when there was a change requiring notification. Further review revealed in an instance of death, the resident's physician was to be notified immediately in accordance with State law. Review of R71's Face Sheet revealed the facility admitted the resident on [DATE]. R71's diagnoses included atherosclerotic heart disease of native coronary artery without angina pectoris, personal history of transient ischemic attack (TIA), cerebral infarction without residual deficits, and old myocardial infarction. Resident 71 expired in the facility on [DATE] Review of the progress note dated [DATE] at 1:57 AM, revealed R71 was abed (staying in bed) with no complaints. The resident's vitals were within normal limits (WNL). Review of the progress note dated [DATE] at 3:15 AM, documented by Licensed Practical Nurse (LPN) 1, revealed the nurse noted going to R71's room and finding the resident with no pulse, respirations, or signs of life. Per review, R71's emergency contact was at the bedside (Resident 2). She stated she did not want any attempts at that time for cardiopulmonary resuscitation (CPR), as the resident had passed peacefully in her sleep. Further review revealed the Nurse Practitioner (NP) was made aware of R71's passing. During interview with R2 (R71's roommate) on [DATE] at 3:45 PM, she stated she was R71's emergency contact. She stated R71 had been sick with pneumonia and they just couldn't get her well. R2 stated she had been awake all hours of the night and morning and at some point, that morning she had woke up and noticed R71 was gone. She stated she pushed her call light, and staff came in the room. R2 further stated she could not remember who all was in the room or what they did because she had been so upset. During interview with the Regional Support Nurse (RSN) on [DATE] at 3:59 PM, she stated she had been the former Unit Manager (UM) at the facility. She stated when she was the UM and arrived at work, she reviewed any events from the previous day and made any needed notifications if they had not been done. The RSN further stated she notified the NP of R71's death after she began her shift on [DATE], so the resident's chart could be closed. During interview with the Director of Nursing (DON) on [DATE] at 4:25 PM, she stated she had been the former Assistant Director of Nursing (ADON). She reported she had been working the evening shift on [DATE]; however, had not been assigned to R71's hall. The DON stated she believed Certified Medication Technician (CMT) 2 had told her the 100-hall nurse needed help. She explained she went to R71's room and the resident was blue, purple, and hard. The DON stated she asked LPN1 what the resident's code status was; however, she felt R71 was too far gone and it was not right to do CPR at that point. She stated she notified the former DON of R71's passing. The DON stated she did not notify the physician since she was not assigned to R71. She stated the nurse assigned to the resident would be the one responsible to notify (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the physician. During interview with the NP on [DATE] at 5:06 PM, she stated the former UM notified her of R71's death shortly after she arrived at the facility on [DATE]. She stated staff were supposed to notify her or the on-call physician of a resident's death immediately or shortly after it occurred. During interview with LPN 1 on [DATE] at 7:45 PM, she stated R71 had been diagnosed with pneumonia and some other illnesses recently. She stated a Certified Nursing Assistant (CNA) had told her R71 was non-responsive. LPN1 stated going to R71's room and the resident was cold, blue and rigor mortis had started to set in. She stated there were no signs of life for R71. The LPN explained she could not recall who called to notify the physician; however, if she documented having done that, then she should have done what she documented. She further stated staff were supposed to call the physician with any change to a resident when the change occurred. During interview with the Medical Director on [DATE] at 10:36 AM, he stated he expected that he or the NP would be notified immediately when a resident passed away. He further stated he did not remember R71, or whether he had been notified of her death. During an additional interview with the NP on [DATE] at 8:35 AM, she stated she did not give 100 percent accurate information during her first interview. She stated LPN 1 had notified her via a text message on [DATE] at 4:51 AM, (one hour and 36 minutes after the resident's death). The NP stated she would expect to be notified immediately of a resident's death. During interview with the Administrator on [DATE] at 4:48 PM, he stated he expected staff to notify the physician or on-call NP immediately after a resident's death.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the facility's policy, the facility failed to ensure the care plan was implemented for one of thirty-three sampled residents, Resident 71 (R71).Immediate Jeopardy (IJ) was identified on [DATE] and was determined to exist on [DATE] in the areas of 42 CFR S483.10 Notification of Changes at the scope and severity (S/S) of a J, 42 CFR 483.21 Comprehensive Care Plans, 42 CFR 483.24 CPR, and 42 CFR 483.35 Nursing Services, at the S/S of a J. Substandard Quality of Care (SQC) was identified at 42 CFR S483.24 On [DATE], at 11:32 AM the Administrator was provided a copy of the CMS Immediate Jeopardy (IJ) Template and notified that the failure to ensure residents' comprehensive person-centered care plans were implemented was likely to cause serious injury, impairment, or death and constituted IJ at 42 CFR 483.210 at F580. The IJ at F678 also constituted Substandard Quality of Care (SQC) at 42 CFR 483.25, Quality of Care. The IJ was determined to exist on [DATE]. R71 was care planned as a Full Code Status with interventions that included to administer Cardio-Pulmonary Resuscitation (CPR). However, the facility failed to provide the CPR. The facility provided an acceptable IJ Removal Plan on [DATE]. The IJ Removal Plan alleged the IJ was removed on [DATE]. The SSA validated the facility's IJ Removal Plan on [DATE]. The SSA validated the immediacy of the IJ had been removed on [DATE], as alleged. (Refer to F678)The findings include: Review of the facility's policy titled, Comprehensive Care Plans, revised [DATE], revealed the facility would develop and implement a comprehensive person-centered care plan for each resident, to meet a resident's medical, physical, mental, and psychosocial needs. Review of R71's Face Sheet revealed the facility admitted the resident on [DATE]. R71's diagnoses included atherosclerotic heart disease of native coronary artery without angina pectoris, personal history of transient ischemic attack (TIA), cerebral infarction without residual deficits, and old myocardial infarction. R71 expired at facility on [DATE]. Review of an Advanced Directives Comprehensive Care Plan, initiated on [DATE] and revised on [DATE], revealed R71 was a Full Code Status. Interventions included to administer CPR if the resident was found without pulse or respirations. Review of a progress note dated [DATE] at 3:15 AM, revealed Licensed Practical Nurse (LPN) 1 was called to R71's room. LPN1 found R1 with no pulse, respirations, or signs of life. The resident's emergency contact (Resident 2) was at the bedside and stated she did not want any attempts at this time for resuscitation. During an interview with Licensed Practical Nurse (LPN) 1 on [DATE] at 7:45 PM, she stated she was assigned to R71 on [DATE]. She stated when she entered R71's room, the resident was blue, cold, and rigor mortis had started to set in. She stated R71 had no signs of life. LPN1 stated R71 was a full code; however, she did not perform CPR or follow R71's care plan or Advanced Directive. LPN 1 stated a resident's code status could be found in the code binder located on the crash cart, in the resident's care plan, and on their face sheet. LPN 1 stated that she and the former ADON/current DON assessed R71 and believed she was too far gone to start CPR even though they were aware of the resident's full code status. During an interview with the Regional Support Nurse on [DATE] at 3:59 PM, she stated she was the (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	former Unit Manager at the facility. She stated if a resident was assessed to have a Full Code Status, she would expect CPR to have been initiated. She stated it would not be acceptable for an emergency contact to give a verbal order to withhold CPR if the resident's wishes were to have CPR performed. She stated that was not the facility's policy. She stated the resident's wishes and the resident's care plan should be followed. During an interview with the Nurse Practitioner (NP) on [DATE] at 5:06 PM, she stated if a resident had a full code status and they were found unresponsive, she would expect CPR to be initiated. She stated she was always taught that if a resident was a full code, you do CPR until Emergency Management Services (EMS) arrived. She stated even if the emergency contact stated they did not want CPR done; she would expect the facility staff to initiate CPR as the resident wishes stated. During an interview with the Medical Director on [DATE] at 10:36 AM, he stated he expected staff to initiate CPR on a resident if they were a full code. During a second interview with the Director of Nursing (DON) on [DATE] at 4:21 PM, she stated she expected staff to follow every resident's care plan interventions. The DON also stated it was important for resident information to be on the care plan, so every staff member knew what they were supposed to do. During an interview with the Administrator on [DATE] at 4:48 PM, he stated he expected staff to follow care plan interventions and code statuses as per physician orders. He stated her expectation was for care plans to be comprehensive and resident centered. He stated accurate care plans were important, so staff knew how to provide appropriate care for each resident.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the facility's policy, the facility failed to ensure Cardiopulmonary Resuscitation (CPR) was initiated for 1 of 33 sampled residents, (Resident (R)71). Staff found R71 on [DATE] without pulse or respirations and unresponsive by staff. Resident was a Full Code status; however, no lifesaving measures were attempted. On [DATE], at 11:32 AM the Administrator was provided a copy of the CMS Immediate Jeopardy (IJ) Template and was notified the failure to ensure residents were provided CPR was likely to cause serious injury, impairment, or death. This failure constituted IJ at 42 CFR 483.24 F678, 42 CFR 483.10 F580, 42 CFR 483.21 F656, and 42 CFR 483.35 F726. The IJ at F678 also constituted Substandard Quality of Care (SQC) at 42 CFR 483.24, Quality of Care. The IJ was determined to exist on [DATE], when R71 was found without pulse or respiration and CPR was not initiated.The facility provided an acceptable IJ Removal Plan on [DATE]. The plan alleged the IJ was removed on [DATE]. An Extended Survey and IJ Removal Validation was conducted on [DATE]. The State Survey Agency (SSA) validated the facility's IJ Removal Plan on [DATE]. The SSA validated the immediacy of the IJ had been removed on [DATE], as alleged. The findings include: Review of the facility's policy titled, Cardiopulmonary Resuscitation (CPR), revised [DATE], revealed the facility would adhere to residents' rights to formulate advance directives. In accordance with these rights, the facility would implement guidelines regarding CPR. The policy further stated staff would maintain current CPR certification for healthcare providers. Review of R71's Face Sheet revealed the facility admitted the resident on [DATE]. with diagnoses that included: atherosclerotic heart disease of native coronary artery without angina pectoris, personal history of transient ischemic attack (TIA/stroke), cerebral infarction without residual deficits, and old myocardial infarction. Resident 71 expired in the facility on [DATE]. Review of a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed the facility assessed R71 to have a Brief Interview for Mental Status (BIMS) score of a 13 out of 15. This score indicated the resident was cognitively intact. Review of a Physician's Order, dated [DATE], revealed an order for R71 to be a Full Code Status. Review of an Advanced Directives Comprehensive Care Plan that was initiated on [DATE] and revised on [DATE], revealed R71 was a Full Code Status. Interventions included to administer CPR in the event that the resident was found without pulse or respirations. Review of a Kentucky Living Will Directive, dated [DATE], signed by R71, revealed the resident's wishes were for life-prolonging treatment not to be withheld or withdrawn. Review of a Physician's Order, dated [DATE], revealed R71's Code status was Full Code. Review of R2's (R71's Emergency Contact) Face Sheet revealed the facility admitted the resident on [DATE] with diagnoses that included atrial fibrillation and bipolar I disorder. Review of a Quarterly MDS with an ARD of [DATE] revealed the facility assessed R2 to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15. This score indicated the resident was cognitively intact. Review of a progress note dated [DATE] at 3:15 AM, revealed Licensed Practical Nurse (LPN) 1 was called to R71's room. LPN1 found the resident with no pulse, respirations, or signs of life. The resident's emergency contact (Resident2) was at the bedside. R2 informed the staff, that she did not want any attempts at this time for resuscitation. The emergency contact stated the resident passed peacefully in her sleep. During an interview with R2 on [DATE] at 3:45 PM, she stated she was the emergency contact for R71. She stated R71 had been sick with pneumonia, and they just could not get her well. R2 stated she was awake all hours of the night and morning and at some point, that morning she had woke up and noticed R71 was gone (had passed). She stated she pushed her call light staff came in the room. R2 stated she could not remember who all was in the room or what they did because she was so upset. R2 stated R71 was her best friend and their families were estranged. During an interview with Certified Nursing Assistant (CNA) 6 on [DATE] at 7:10 PM, she stated while rounding (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	on the morning of [DATE], she entered R71's room and noticed the resident was blue, her hand was cold, her mouth was starting to become stiff, and her chest was not rising. CNA 6 stated she yelled for help. She stated CNA 5 came into the room and immediately left to get the nurse. She stated Licensed Practical Nurse (LPN) 1 came to R71's room and said the resident was too far gone to perform CPR. She stated they were aware that R71 was a full code and could find that information in the electronic medical record (EMR) or in the code binder that was kept on the crash cart. During an interview with LPN1 on [DATE] at 7;45 PM, she stated she was assigned to R71 on [DATE] up until the resident's death on [DATE]. She stated when she entered R71's room, she (the resident) was blue, cold, and rigor mortis had started to set in. She stated R71 had no signs of life. LPN1 stated R71 was a full code. She stated that resident's code status could be found in the code binder located on the crash cart, in the resident's care plan, and on their face sheet. LPN1 stated that she and the former ADON/current DON (Assistant Director of Nursing/Director of Nursing) had assessed R71 and believed she was too far gone to start CPR even though they were aware of the resident's full code status. During an interview with the Regional Support Nurse on [DATE] at 3:59 PM, she stated she was the former Unit Manager at the facility. She stated if a resident was assessed to have a Full Code Status, she would expect CPR to have been initiated. She stated it would not be acceptable for an emergency contact to give a verbal order to withhold CPR if the resident's wishes were to have CPR performed. She stated that was not the facility's policy. Review of LPN 1's personnel record revealed a CPR certification date of [DATE]. There was no documented evidence of prior CPR certification. During an interview with the Staff Development Coordinator (SDC) on [DATE] at 4:14 PM, she stated she was responsible to ensure staff were CPR certified. She further stated most of the nurses should be CPR certified but there may be a couple that had expired, and she had been working on that. Additionally, she stated she expected staff to follow facility policy and orders when CPR should be performed. During an interview with the Director of Nursing (DON) on [DATE] at 4:25 PM, she stated she had been the former Assistant Director of Nursing. She stated she was working the evening shift on [DATE] but was not assigned to R71's hall. She stated she believed Certified Medication Technician (CMT) 2 came to get her and informed her that the 100-hall nurse needed help. She stated she went to R71's room and the resident was blue, purple, and hard. She stated she asked LPN1 what the resident's code status was, but she felt that she was too far gone, and it was not right to do CPR at that point. She stated she did look into why CPR was not initiated because she had some concerns as well. However, she did state what her concerns were related to CPR. The DON stated she did not initiate CPR due to R71's condition but typically a resident with a full code status should have had CPR initiated. During an interview with the Nurse Practitioner (NP) on [DATE] at 5:06 PM, she stated if a resident had a full code status and they were found unresponsive, she would expect CPR to be initiated. She stated she was always taught that if a resident was a full code, you do CPR until Emergency Management System (EMS) arrived. She stated even if the emergency contact stated they did not want CPR done; she would expect the facility staff to initiate CPR as the resident wishes stated. During an interview with the Medical Director on [DATE] at 10:36 AM, he stated he expected staff to initiate CPR on a resident if they were a full code. During an interview with the Administrator on [DATE] at 4:48 PM, he stated he would expect staff to follow the resident's care plan interventions and code statuses as per physician orders. The Administrator stated he was unable to provide documentation that LPN 1 had an active CPR certification at the time of R71's death.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. AMENDED Based on observations, interviews, record reviews, and review of facility policy, the facility failed to ensure residents received an accurate Minimum Data Set (MDS) assessment that was reflective of the resident's status at the time of the assessment for three of thirty-three sampled residents (Residents 30, 58, and 59).The findings include: Review of The Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.19.1 Chapter 1 Section 3 dated 10/01/2024, revealed the Resident Assessment Instrument process had multiple regulatory requirements, including the requirement that the assessment accurately reflected the resident's status. Continued review of the RAI User's Manual revealed the assessment process included direct observation, as well as communication with the resident and direct care staff on all shifts. Review of the facility's policy titled, Documentation in Medical Record, revised 03/01/2025, revealed it was the facility's policy that each resident's medical record contained an accurate representation of the actual experiences of the resident. The assessment would include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. 1. Review of R30's Face Sheet revealed the facility admitted R30 on 06/04/2025 with diagnoses which included acute kidney failure, idiopathic aseptic necrosis of unspecified bone, and generalized anxiety disorder. Review of R30's History and Physical, dated 06/02/2025, documented vaping use as every day with the substances of nicotine and tetrahydrocannabinol (THC or marijuana). Review of the Risk Assessment Bundle, dated 06/04/2025, revealed yes to the question Does the resident plan to use tobacco products during stay and indicated the type of smoking product the resident would use as E-cigarettes/Vape. The facility assesses R30 to be a safe smoker and required no supervision. Review of R30's care plan titled R30 participates in smoking activities utilizing a vape with a start date of 06/05/2025. Review of R30's MDS assessment with an ARD of 06/09/2025 revealed the facility assessed R30 with a BIMS score of 15 out of 15, indicating intact cognition. Continued review of the MDS Assessment Section J1300: Current Tobacco Use, revealed the facility coded R30 as a 0, indicating there was no current tobacco use. 2. Review of R58's Face Sheet revealed the facility admitted the resident on 12/16/2024 with diagnoses which included fusion of spine, cervical region, pseudarthrosis after fusion, and cerebral infarction due to embolism of unspecified cerebral artery. Review of History and Physical, dated 12/12/2024, documented R58 as a smoker. Review of the facility's Release of Responsibility for Leave of Absence revealed that 01/18/2025 through 07/31/2025, R58 was signed out 495 times. The resident's sign out was to smoke. Review of (R) 's 58's Comprehensive MDS assessment with an ARD date of 07/31/2025 revealed the facility assessed R58 had a BIMS' score of 11 out of 15, indicating moderate cognitive impairment. Continued review of the MDS Assessment Section J1300: Current Tobacco Use, revealed the facility coded R58 as a 0, indicating there was no current tobacco use. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of R59's Face Sheet revealed the facility admitted the resident on 03/01/2025 with diagnoses which included type 2 diabetes mellitus, adjustment disorder with mixed anxiety and depressed mood, and depression. Review of R59's care plan revealed a problem of R59 participates in smoking activities utilizing smoking tobacco with a start date of 03/02/2025. Review of R59's Comprehensive MDS assessment with an ARD of 03/16/2025 revealed the facility assessed R59 with a BIMS' score of 15 out of 15, indicating intact cognitive function. Review of the MDS Assessment Section J1300: Current Tobacco Use, revealed the facility coded R59 as a 0, indicating there was no current tobacco use. In an interview on 08/11/2025 at 3:41 PM, the MDS Coordinator stated she gathered information for the MDS assessments from the nurses' evaluations, nurses' notes, Certified Nurse Aide Point of Care documentation, and therapy documentation. She stated R58 smokes occasionally and her family takes her out then. In an interview the MDS Nurse on 08/11/2025 at 3:48 PM, she stated that having an incorrectly coded MDS could result in the facility getting fined, or having to return any monies dispersed or could affect a resident's care. In an interview with the Director of Nursing (DON) on 08/11/2025 at 4:22 PM, she stated that someone came in from corporate that audited the MDS assessments. She stated she would expect all residents to have completed MDS assessments. In an interview with the Administrator on 08/11/2025 at 4:46 PM, he stated he expected that the MDS assessments were completed, monitored, and documented as completed. He stated if there was a mistake on the assessment, he expected it to be modified appropriately.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and review of facility policy, it was determined that the facility failed to formulate an advance directive at the discretion of the resident for four of thirty-three sampled residents (R) (R6, 22, 51, and 55). The findings include: Review of the facility's Advance Directive Policy revised on [DATE], revealed it was the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an Advance Directive. 1.Record review revealed the facility admitted R51 on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD), bronchopneumonia, generalized anxiety disorder, bipolar type. Review of (R) 51's Annual Minimum Data Set (MDS) dated [DATE] revealed the facility assessed R51 to have a Brief interview for Mental Status score (BIMS) of 15 out of 15 which indicated intact cognition. In an interview with R51on [DATE] at 3:45 PM, she stated that she was a full code. R51 stated she was aware (CPR) cardiopulmonary resuscitation was involved in the process. However, review of Resident 51's (R51) Advance Directives/Medical Treatment Decisions, dated [DATE] and signed by the resident, revealed no directive detailing R51's decision to prolong her life and have life sustaining treatment to be provided. 2. Review of R22's Face Sheet revealed the facility admitted the resident on [DATE]. R22's diagnoses included incomplete paraplegia, obsessive compulsive disorder, and borderline personality. Review of (R) 22's Annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of [DATE] revealed R22 had a Brief Interview for Mental Status Score (BIMS) of fifteen (15) out of fifteen (15). This score indicated intact cognition. Review of R22's, Advanced Directives/Medical Treatment Decisions, dated [DATE], revealed one version of the document was signed by the resident, but no directive was indicated on the form. Review of a second version of the same form indicated R22 wished to have efforts made to prolong her life and have life-sustaining treatment provided. In an interview with Resident 22 on [DATE] at 4:00 PM, she stated that she was a full code, and that she had formulated an Advanced Directive when she was admitted to the facility. She stated that the Social Services Director came to speak with her this week and asked her what her wishes were, and she stated to her that she was a full code, but she did not sign a new form. In an interview with the Social Services Director (SSD) on [DATE] at 2:51 PM, she stated that on the advance directives form she printed off for R (22) the box was not marked. In an interview with the Administrator on [DATE] at 4:46 PM, he stated he did not have an answer on who marked the advance directive form for Resident 22 or how it got marked after the fact. The Administrator stated he expected staff to complete the necessary forms per facility policy. 3. Review of R55's electronic medical record (EMR) revealed the facility admitted the resident on (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE], with diagnoses to include: chronic obstructive pulmonary disease (COPD), heart disease, and type 2 diabetes mellitus with diabetic polyneuropathy. Review of the Comprehensive Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed the facility assessed R55 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident had intact cognitive function. Review of R55's EMR revealed the resident had a Do Not Resuscitate (DNR) Status. Review of an Advance Directives/Medical Treatment Decisions form, dated [DATE], revealed below the resident signature line an unclear set of initials. In an interview on [DATE] at 2:59 PM, the SSD identified the Advance Directives/Medical Treatment Decisions form, dated [DATE] acknowledging the DNR status and signed by an unclear set of initials, as belonging to R55. The SSD acknowledged there was no resident's name on the form anywhere. 4. Review of R6's EMR revealed the facility admitted the resident on [DATE]. R22's diagnoses included cerebrovascular accident (CVA), paraplegia, and aphasia. Review of the Quarterly MDS, with an ARD of [DATE], revealed the facility assessed R6 to have a BIMS's score of 6 out of 15. This score indicated the resident had severe cognitive impairment. Review of R6's EMR revealed a DNR status. Review of an Advance Directives/Medical Treatment Decisions form, dated [DATE], revealed the signature of R6's legal representative. However, on the line requesting if legal representative signed . print name the name printed was the resident's name with the relationship to resident noted as guardian. The line asking type of legal appointment remained blank. In an interview on [DATE] at 2:59 PM, the Social Services Director (SSD) stated the form was incorrectly filled out, that it should have been the representative's name printed and not the resident's name. She also stated the type of legal appointment should not be blank. In an interview with the Social Services Director (SSD) on [DATE] at 2:51 PM, she stated that she completes the assessments for Brief Interview for Mental Status (BIMS) Patient Health Questionnaire-9 (PHQ-9), Social History, and Advance Directives. She stated assessments were completed on admission, quarterly, annually as well if there were any significant changes. The Social [NAME] Director stated that if a resident wanted to change their code status she would help initiate the process.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of facility policy, the facility failed to ensure the services provided or arranged by the facility met professional standards of quality for one of thirty-three sampled residents (R71). Record review and interviews revealed R71's provisional death certificate was signed by the Staff Development Coordinator (SDC) prior to R71's death. The findings include: The facility was unable to provide a policy related to provisional death certificates.Review of the facility's policy titled, Documentation in Medical Record, revised [DATE], revealed each resident's medical record should contain an accurate representation of the actual experiences of the resident and include information to provide a picture of the resident's progress through complete, accurate, and timely documentation. The policy further stated documentation should be completed at the time of service. Review of the facility's policy titled, Death of a Resident, Documenting, reviewed 06/2025, revealed appropriate documentation should be made in the clinical record concerning the death of a resident.Review of R71's Face Sheet revealed the facility admitted the resident on [DATE] with diagnoses which included: atherosclerotic heart disease of native coronary artery without angina pectoris, cerebral infarction without residual deficits, and old myocardial infarction. The facility discharged R71 due to death in the facility on [DATE].Review of an Advisory Opinion: Pronouncement of Death and Signing Death Certificates from the Kentucky Board of Nursing, revealed a Registered Nurse was authorized to sign the provisional report of death as furnished by the state registrar of vital statistics. However, review of R71's Provisional Death Certificate, dated [DATE], revealed it was signed by the Staff Development Coordinator (SDC) and witnessed by Licensed Practical Nurse (LPN) 1.Review of the facility's staffing schedule dated [DATE] revealed the SDC was not scheduled to work on the 7P-7A shift.During an interview with Licensed Practical Nurse (LPN) 1 on [DATE] at 7:45 PM, she stated she was assigned to R71 on [DATE] up until her death on [DATE]. She stated when she entered R71's room, she was blue, cold, and rigor mortis had started to set in. LPN1 stated R71 had no signs of life. She stated R71 was a full code. LPN1 stated that she and the former ADON/current DON (Assistant Director of Nursing/Director of Nursing) had assessed R71 and believed she was too far gone to start CPR (cardiopulmonary resuscitation) even though they were aware of the resident's full code status. LPN 1 stated she received CPR training in [DATE]. She stated she could not recall if she had an active CPR certification at the time of R71's death. She stated as an LPN, she was not permitted to sign a Provisional Death Certificate, but she had filled one out in the past after a resident had expired. She stated the SDC had signed some blank ones and left them at the nursing desk. LPN 1 was also unable to recall who completed R71's Provisional Death Certificate.During an interview with the SDC on [DATE] at 4:14 PM, she stated she was not working the morning of R71's death and she did not come to the facility at the time of R71's death to sign the provisional death certificate. She stated if her signature was on the report then she should have been at the facility. She further stated that she had signed a few blank provisional death certificates and kept them on each unit. The SDC stated that was what she was told to do by the Administrator when she took the SDC position. She stated since the forms were signed, the LPN working the floor could fill out the form and have another LPN to witness. Additionally, she stated though an LPN could sign the certificates as long as they had a witness. She stated that she or another RN were not usually in the facility during the evening shift (7P-7A) and that was another reason the forms were pre-signed. She stated there was an RN on call and staff did not notify them when something happened, but she did not typically come to the facility to pronounce death or sign a provisional death certificate. During an interview with the Director of Nursing (DON) on [DATE] at 4:25 PM, she stated she was working the evening shift (7P-7A) on [DATE] when R71 expired. She stated since she was working, she should have signed R71's provisional death certificate. She stated the SDC may have come in to sign it since she lived close by. The DON stated there were some pre-signed provisional death certificates at the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing stations that LPNs could complete. She stated she thought LPNs were allowed to do that. The DON stated there was not an RN in the facility most of the time but could come in if needed. She stated she would expect staff to sign a provisional death certificate at the time the death occurred.During an interview with the Medical Director on [DATE] at 10:36 AM, he stated he would not expect staff to sign provisional death certificates until the resident had expired. He stated he would not sign a death certificate until it actually occurred, that was common sense.During an interview with the Administrator on [DATE] at 4:48 PM, he stated a provisional death certificate should not be signed or completed until the time of death or soon after. He stated he would not expect staff to sign them before then. He stated he had never instructed staff to sign a provisional death certificate in advance.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview, record review, and facility policy review, the facility failed to ensure performance review evaluations were completed for every Certified Nursing Assistant (CNA) at least once every 12 months for 4 of 6 CNAs' personnel records reviewed, (CNA2, CNA6, CNA17, and CNA20). The findings include:Review of the facility's policy titled, Nursing Services and Sufficient Staff, revised 02/03/2025 revealed sufficient staff with appropriate competencies and skill sets were to be provided to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. In addition, the facility must ensure that nurse aides were able to demonstrate competency in skills and techniques necessary to care for residents.The Administrator did not provide a Performance Evaluation policy. However, the Administrator's job description dated December 2018 stated job duties included: communicate policies, evaluate performance, provide feedback, assist, observe, and coach.1. Review of CNA 2's personnel file revealed the facility hired the CNA on 03/19/2024. Further review revealed CNA 2 had completed 24.5 hours of training between 07/15/2024 - 12/05/2024. However, there was no documentation of a performance evaluation during the 12-month period. 2. Review of CNA16's personnel file revealed a hire date of 07/27/2022. Further review revealed CNA16 had completed 37.5 hours of training between 01/23/2025 - 07/06/2025. However, there was no documentation of a performance evaluation during the 12-month period.3. Review of CNA17's personnel file revealed a hire date of 05/13/2024. Further review revealed CNA 17 had completed 33.57 hours of training between 03/06/2025-07/15/2025. Further review revealed no documentation of a performance evaluation during the 12-month period.4. Review of CNA 20's personnel file revealed hire date of 04/21/2022. Further review revealed the last evaluation completed was in 2022, with no documentation of performance evaluation during the last 12-month period. During an interview with the Director of Nursing (DON) on 08/11/2025 at 4:32 PM, she stated that she would begin training regarding performance evaluations to begin the yearly evaluation process since she was new to the position. During an interview with the Administrator 08/11/2025 at 5:00 PM, he stated yearly performance evaluation were beneficial; however, he failed to complete them on his part. He stated areas of improvement were not identified when performance evaluations were not completed.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility policy review, the facility failed to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This deficient practice had the potential to affect all residents requiring Cardiopulmonary Resuscitation (CPR).The findings include: Review of the facility's document titled, Administrator Job Description, dated 12/2018, revealed the Administrator was to lead and direct the overall operations of the facility in accordance with the customer (resident) needs, government regulations, and company policies. Per review, the Administrator's focus was on maintaining excellent care for the residents while achieving the facility's business objectives. Continued review revealed the Administrator's essential duties included monitoring each department's activities and evaluating performance. Further review revealed the Administrator was also to consult with the department managers concerning the operation of their departments to assist in eliminating/correcting problem areas and/or improvement of services and to provide guidance and leadership to ensure state and federal regulations were met. 1). Review of the facility's policy titled, Cardiopulmonary Resuscitation (CPR), revised [DATE], revealed the facility was to adhere to residents' rights to formulate advance directives (for its residents). Per review, the policy further noted staff were to maintain current CPR certification for healthcare providers. Review of the facility's Registered Nurse (RN), and Licensed Practical Nurse (LPN) Job Descriptions updated [DATE], revealed they must have a current/active CPR certification. Review of the facility's Certified Nurse Aide (CNA) job description dated 12/2018, revealed a current/active CPR certification was preferred. However, review of personnel records for 15 out of 21 licensed or certified staff revealed they were not up to date with their CPR certifications. Review of R71's Face Sheet revealed the facility admitted the resident on [DATE]. R71 expired in the facility on [DATE]. Review of R71's Advanced Directives Comprehensive Care Plan initiated on [DATE] and revised on [DATE], revealed the resident had a Full Code Status with interventions that included administering CPR in the event the resident was found without pulse or respirations. Review of R71's Kentucky Living Will Directive, dated [DATE], revealed it had been signed by the resident, and noted her wishes were for life-prolonging treatment not to be withheld or withdrawn. Review of the physician's order dated [DATE], revealed R71's code status was ordered as Full Code. Review of the progress note for R71 dated [DATE] at 3:15 AM, revealed LPN1 was called to the resident's room, where she was found with no pulse, respirations, or signs of life. The nursing staff did not provide CPR. Review of the facility's personnel records reviewed revealed 15 of the 21 licensed or certified staff sampled were not CPR certified at the time of R71's death on [DATE]. Per review, staff received their CPR certifications on the following dates: on [DATE]- Certified Medication Aide (CMA) 1, Licensed Practical Nurse (LPN)1, LPN2, LPN4, and Registered Nurse (RN/Director of Nursing (DON); on [DATE]- LPN 9; on [DATE]- CMA 3, CMA 4, CMA 5, LPN 6, LPN 7, LPN 8 LPN 10, RN 1, and RN 2. During an interview with the Staff Development Coordinator (SDC) on [DATE] at 4:14 PM, she stated (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was responsible for ensuring staff were CPR certified as required. She stated most of the nurses should be CPR certified, but there might be a couple whose CPR had expired, and she had been working on that. The SDC stated she expected staff to follow the facility's policy and orders for when CPR should be performed. In an additional interview with the SDC on [DATE] at 9:25 AM, she stated, When I started this position 4-5 years ago, the Administrator told me it was not required for licensed staff to have an active CPR certification. She further stated it was in the job descriptions for licensed staff, and she knew they were supposed to have been CPR certified. During interview with the Director of Nursing (DON) on [DATE] at 4:25 PM, she stated she had been the facility's former Assistant Director of Nursing (ADON). She stated she had been working the evening shift on [DATE]. The DON stated she had not initiated CPR due to R71's condition, but typically if a resident had a full code status CPR should have been initiated. She further stated she started at the facility about a year ago and had not been CPR certified until [DATE]. During interview with Licensed Practical Nurse (LPN) 1 on [DATE] at 7:45 PM, she stated she had assigned to R71's care on [DATE], and up until her death. She stated that she and the former ADON/current DON did not start CPR even though they were aware the resident was a full code. LPN 1 further stated she received CPR training in [DATE] and could not recall if she had been actively certified in CPR at the time of R71's death. During interview with the Administrator on [DATE] at 4:48 PM, he stated he expected the facility to have proper monitoring of which staff were to be certified in CPR. The Administrator explained he had instructed the SDC that the facility should have licensed and certified staff active in their CPR certifications. He stated however, a CNA was preferred to have CPR, but it was not required for them. The Administrator stated there should have been better communication among the staff, and he knew there needed to be a lot of improvements made in the facility. He stated knowing if CPR certifications were active or not was not something he personally tracked on his own, but it was also a requirement of the facility. He further stated he should have been overseeing the CPR certification and would be doing that going forward. In interview with the Administrator on [DATE] at 6:02 PM, he stated the facility had QAPI plans and actions and tracked all quality improvement activities. He stated the facility had not identified the issue with the CPR problems prior to the survey team entering the facility. The Administrator stated, We were not aware of any systemic issues. He stated the facility had a QAPI meeting today with the DON, Social Services Director, Infection Control/Staff Development Coordinator, Maintenance Director, Dietary Manager, MDS Coordinator, Nurse Practitioner, and several other staff members attended the meeting. The Administrator stated the Medical Director participated in the meeting via the telephone. He stated the meeting included information regarding, Care Plan Compliance, Staff Education with CPR, Code Status, Education, and Audits. He further stated, going forward education would include better communication with staff to ensure nursing administration was aware of incidents that may or may not occur in the facility that indicated staff needed education.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185309	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring View Nursing & Rehabilitation	718 Goodwin Lane Leitchfield, KY 42754

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 - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and facility policy review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of five sampled residents reviewed for infection control (Resident (R)73).The findings include:Review of the facility's policy titled, Transmission-Based Precautions, revised 05/21/2025, revealed the facility would take appropriate precautions to prevent transmission of infectious agents. Further review revealed for a resident on Contact Precautions, staff should don (put on) personal protective equipment (PPE) upon room entry (gown and gloves).Review of the facility's policy titled, Infection Prevention and Control Program, revised 02/02/2025, revealed the facility had established and maintained an infection prevention and control program. The program was designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.Review of Resident 73's (R73) Face Sheet revealed the facility admitted the resident on 09/29/2020 with diagnoses which included necrotizing fasciitis, methicillin resistant staphylococcus aureus infection, and pressure ulcer of unspecified site, unspecified stage. Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/24/2025, revealed the facility assessed R73 to have a Brief Interview for Mental Status (BIMS) score of five out of 15, indicating the resident was severely cognitively impaired.Review of a physician order, dated 06/23/2025, revealed R73 was placed on Contact Isolation Precautions related to a wound infection. Review of R73's wound culture result, dated 07/31/2025, revealed diagnoses of methicillin-resistant staphylococcus aureus (MRSA), enterococcus faecium, and Escherichia coli. Recommendations included to establish Contact Isolation.Observation on 08/10/2025 at 10:00 AM, revealed a sign on R73's door that the resident was on Contact Precautions. Further observation revealed Certified Medication Assistant (CMA) 1 administering medication to R73 without wearing a gown or gloves.During an interview with CMA1 on 08/10/2025 at 10:15 AM, she stated she did not think she needed to wear a gown or gloves since she was not doing direct care. After CMA1 read the Contact Precaution sign on R73's door, she stated she should have put on a gown and gloves before she went into R73's room. CMA 1 stated it was important to do so to prevent the spread of infection.During an interview with the Staff Development Coordinator (SDC)/Infection Preventionist (IP) on 08/11/2025 at 9:25 AM, she stated she had educated all staff on Infection Control. She stated staff were expected to wash their hands and put on PPE prior to entering a resident's room. The SDC stated staff could pass things to other residents if they went room to room without washing their hands or wearing appropriate PPE. She stated she did audits and observations on a weekly basis of staff wearing their PPE and had not had any concerns.During an interview with the Assistant Director of Nursing (ADON) on 08/11/2025 at 10:28 AM, she stated any resident that was in isolation had a sign and isolation tote with supplies hanging on their door. She stated staff should put on PPE before entering rooms for residents on Contact Precautions. The ADON further stated she expected staff to wear PPE per the facility's policy.During an interview with the Director of Nursing (DON) on 08/11/2025 at 2:45 PM, she stated she expected staff to wash their hands and don PPE before going into a resident's room. She stated she thought staff were confused with Enhanced Barrier Precautions and Contact Precautions. The DON stated the facility hosted a skills fair about a month ago which covered infection control. She stated there could be an increased risk of spreading infections when you do not wear proper PPE.During an interview with the Administrator on 08/11/2025 at 4:48 PM, he stated he expected staff to perform proper hand hygiene and put on PPE at the door prior to entering. He stated it could cause potential problems if they did not have the proper gear on.