STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195214	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ferncrest Manor Living Center	14500 Haynes Blvd. New Orleans, LA 70128

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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	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** 46683 Based on record reviews, observations, and interviews, the facility failed to: 1.) Ensure a careplan with measureable interventions was developed for a resident receiving oral antibiotics and wound care for contact dermatitis for 1 (Resident #6) of 4 (Resident #6, Resident #51, Resident #474, and Resident #475) sampled residents reviewed for infection control; 2.) Ensure a careplan with measureable interventions was developed for a resident receiving hospice services for 1 (Resident #474) of 2 (Resident #12 and Resident #474) sampled residents reviewed for hospice services; and, 3.) Ensure a careplan with measureable interventions was developed for a resident with an indwelling urinary catheter for 1 (Resident #474) of 2 (Resident #92 and Resident #474) sampled residents reviewed for urinary catheters. Findings: Resident #6 Review of Resident #6's electronic medical record (EMR) revealed Resident #6 was admitted to the facility on [DATE] with a diagnosis of Gastrostomy status (a surgical inserted tube in the stomach). Further review revealed, Resident #6 returned to the facility on [DATE] after an emergency room visit with a diagnosis of Contact Dermatitis. Review of Resident #6's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/12/2024 revealed, in part, Resident #6's Brief Interview for Mental Status Score (BIMS) was a 99 which indicated Resident #6 was rarely understood and unable to complete the interview. Review of the Resident #6's After Visit Summary dated 05/07/2024 revealed, in part, Resident #6 was discharged from the hospital with an order for Cephalexin (a medication used to treat infections) 250 milligrams(mg) in 5 milliliters (mL) suspension. Review of Resident #6's Wound Management Detail Report, dated 05/07/2024 , revealed, in part, Resident #6 had a 10 centimeter (cm) wide by 10 cm long left lower abdominal wound. (continued on next page)

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	There was no documented evidence and the facility did not present any documented evidence that a plan of care had been developed with measureable interventions to reflect Resident #6's change in condition after Resident #6 returned from the hospital on 05/07/2024 with an order for oral antibiotics and a left lower abdominal wound. In an interview on 05/16/2024 at 2:00 p.m., S2Director of Nursing (DON) stated Resident #6's care plan was not developed with measurable interventions to reflect Resident #6's change in condition after Resident #6 returned to the facility from the hospital on 05/07/2024 with an order for oral antibiotics and a left lower abdominal wound and it should have been. Resident #474 Review of Resident #474's EMR revealed Resident #6 was admitted to the facility on [DATE] with a diagnosis of Respiratory failure, Gastrostomy status, and Tracheostomy status. Review of Resident #474's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/08/2024 revealed, in part, Resident #474's Brief Interview for Mental Status Score (BIMS) was a 99 which indicated Resident #474 was rarely understood and unable to complete the interview. Review of Resident #474's May 2024 Physicians Orders revealed, in part an order dated 04/10/2024 for Resident#474's catheter to be changed every month and as needed. Further review revealed an order dated 05/05/2024 for Resident #474 to admit to hospice services. Observation on 05/13/2024 at 11:47 a.m. revealed Resident #474 lying in bed with an indwelling urinary catheter in place. Observation on 05/14/2024 at 11:50 a.m. revealed Resident #474 lying in bed with an indwelling urinary catheter in place. Observation on 05/15/2024 at 3:00 p.m. revealed Resident #474 lying in bed with an indwelling urinary catheter in place. There was no documented evidence and the facility did not present any documented evidence that a plan of care had been developed with measureable interventions after Resident #474 was admitted to hospice services. Further review revealed, there was no documented evidence and the facility did not present any documented evidence that a plan of care had been developed with measureable interventions for Resident #474's indwelling urinary catheter. In an interview on 05/16/2024 at 2:00 p.m., S2DON stated Resident #474's care plan was not developed with measurable interventions upon her being admitted to hospice services and upon having received an indwelling urinary catheter it should have been.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22609 Based on observations and interviews the facility failed to have a resident with clean and trimmed fingernails for 1 (Resident #74) of 2 sampled residents reviewed for activities of daily living care (Resident #50 and Resident #74) in a total sample of 41 residents. Findings: Review of Resident #74's Minimum Data Set (MDS) dated [DATE] revealed, in part, Resident #74 was assessed as having a brief interview for mental status score as a 5 which indicated Resident #74 was severely impaired. Further review of the MDS revealed Resident #74 required substantial/maximal assistance for shower/bathing. Observation on 05/13/2024 at 10:15 a.m., revealed Resident #74's fingernails had an unknown black substance below his fingernails and some fingernails were approximately 3/16 inches long or longer. Observation on 05/14/2024 at 11:11 p.m., revealed Resident #74's fingernails had an unknown black substance below his fingernails and some fingernails were approximately 3/16 inches long or longer. In an interview on 05/13/2024 at 11:18 a.m., S14Licensed Practical Nurse indicated after assessing Resident #74's fingernails some of his fingernails were too long and some had an unknown black substance under the fingernails which needed care. In an interview on 05/15/2024 at 1:52 p.m., S2Director of Nurses indicated Resident #74' fingernails should have been trimmed and cleaned. In an interview on 05/16/2024 at 10:00 a.m., S13Assistant Director of Nursing (ADON) indicated Resident #74 had a bed bath every day for the month of May from 05/01/2024 to 05/15/2024 per Resident #74's Certified Nursing Assistant Flow Sheet but there was no documentation of nail care being performed. S13ADON further indicated nail care for Resident #74 should have been provided as needed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46683 Based on record reviews, observations, and interviews, the facility failed to ensure a resident's indwelling urinary catheter (a tube that is passed through the lower abdominal wall directly into the bladder to drain urine) was secure to prevent pulling for 1 (Resident #475) of 4 (Resident #6, Resident #51, Resident #474, and Resident #475) sampled residents reviewed for infection control. Findings: Review of Resident #475's electronic medical record revealed, in part, Resident #475 was admitted to the facility on [DATE]. Review of Resident #475's Minimum Data Set with an Assessment Reference Date of 04/29/2024 revealed, in part, Resident #475 was dependent on staff for toileting. Review of Resident #475's May 2024 Physicians Orders revealed, in part an order dated 02/26/2024 for staff to assure a securement device such as a Stat Lock (a device used to secure an indwelling urinary catheter to a residents lower extremity) with Resident #475's indwelling urinary catheter was in place to her lower extremity every shift. Review of Resident #475's Comprehensive Care Plan dated 05/24/2024 revealed, in part, Resident #475 had a indwelling urinary catheter and staff should avoid pulling on catheter tubing. Observation on 05/14/2024 at 9:45 a.m. revealed Resident #475's indwelling urinary catheter was lying under her left lower extremity without a securement device in place. Observation on 05/15/2024 at 9:27 a.m. revealed S9Wound Care Nurse Licensed Practical Nurse (WCLPN) entered Resident #475's room to provide wound care. Observation revealed Resident #475's foley catheter tubing lying under Resident #475's left leg. Observation revealed S16CNA proceeded to assist S9WCLPN perform wound care on Resident #475, turned Resident #475 on her left side, which caused Resident #475's catheter to be pulled taunt. Observation further revealed Resident #475's indwelling urinary catheter without a securement device in place. Observation on 05/15/2024 at 10:25 a.m. revealed, S10Registered Nurse entered Resident #475's room to provide catheter care. Observation further revealed Resident #475's indwelling urinary catheter without a securement device in place. In an interview on 05/15/2024 at 2:45 p.m., S13Infection Preventionist/Assistant Director of Nursing (IC/ADON) stated Resident #475 did not have a securement device in place for her indwelling urinary catheter and she should have. In an interview on 05/15/2024 at 3:30 p.m., S2Director of Nursing (DON) confirmed further Resident #475 did not have a securement device in place to ensure her catheter tubing was not pulling and she should have.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46683 Based on record reviews and interviews, the facility failed to ensure a resident's medication was available for use and administered as ordered for 1 (Resident #6) of 1 (Resident #6) sampled residents reviewed for infection control. Findings: Review of Resident #6's electronic medical record (EMR) revealed Resident #6 was admitted to the facility on [DATE] with a diagnosis of Gastrostomy status. Further review revealed, Resident #6 returned to the facility on [DATE] after an emergency room visit with a diagnosis of Contact Dermatitis. Review of Resident #6's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/12/2024 revealed, in part, Resident #6's Brief Interview for Mental Status Score (BIMS) was a 99 which indicated Resident #6 was rarely understood and unable to complete the interview. Review of the Resident #6's After Visit Summary dated 05/07/2024 revealed, in part, Resident #6 was discharged from the hospital with an order for Cephalexin (a medication used to treat infections) 250 milligrams(mg) in 5 milliliters (mL) suspension. Further review revealed, Resident #6 was to receive 10ml of Cephalexin per gastric tube three times a day for 7 days. Review of Resident #6's May 2024 Physician Orders, revealed, an order with a start date 05/08/2024 for Cephalexin suspension 250mg/5ml- administer 10ml by gastric tube three times a day. Further review revealed an end date of 05/15/2024. There was no documented evidence and the facility did not present any documented evidence that an order was obtained from the physician to hold Resident #6's Cephalexin. Record Review of Pharmacy Delivery Report for Resident #6 for 05/08/2024 revealed, in part, Resident #6's Cephalexin 250mh/5ml suspension was received on 05/08/2024 at 4:02 p.m. Review of Resident #6's Electronic Medication Administration Record (eMAR) revealed no documentation of administration of Cephalexin 250mh/5ml suspension on 05/08/2024 at 6:00am, 2:00 p.m., 10:00 p.m., 05/09/2024 at 06:00a a.m., and 05/11/2024 at 6:00 a.m. Review revealed on 05/08/2024 at 6:00 a.m. S19Licensed Practical Nurse (LPN) documented Resident #6's Cephalexin was not administered due to the drug not being available. Review revealed on 05/08/2024 at 2:00 p.m. S20Registered Nurse (RN) documented Resident #6's Cephalexin was not administered due to the facility waiting on pharmacy delivery. Further review revealed on 05/08/2024 at 10:00 p.m. S21RN documented Resident #6's Cephalexin was not administered due to the drug not being available. In an interview on 05/16/2024 at 10:55 a.m., S2Director of Nursing (DON) confirmed the facility's emergency medication kit contained Cephalexin 250mg. S2DON further stated if Resident #6's Cephalexin could not be obtained by the pharmacy, Resident #6's physician should have been contacted for an order to change or hold the medication until it was received and he was not.

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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** 22609 Based on record reviews, observations, and interviews, the facility failed to: 1.) Ensure enhanced barrier precautions were implemented for a resident with an indwelling device or wound for 5 (Resident #6, Resident #51, Resident #111, Resident #474 and Resident #475) of 5 (Resident #6, Resident #51, Resident #111, Resident #474 and Resident #475) residents reviewed for enhanced barrier precautions; 2.) Ensure resident care items were identified and contained. 3.) Ensure nursing staff removed their gloves and completed hand hygiene while performing gastrostomy dressing changes for 1 (S10Registered Nurse (RN) of 1 (S10RN) RNs and 1 (S17Licensed Practical Nurse (LPN)) of 1 (S17LPN) LPNs observed for gastrostomy tube dressing changes; and, 4.) Ensure the wound care nurse properly contained and disposed of a residents visibly soiled dressing for 1 (S9Wound Care Nurse/ Licensed Practical Nurse (WCLPN) of 1 (S9Wound Care Nurse/ Licensed Practical Nurse (WCLPN) nurses observed for wound care. Findings: Review of the facility's Enhanced Barrier Precautions policy dated 04/01/2024 revealed, in part, enhanced barrier precautions were indicated for resident with wounds and/or indwelling medical devices regardless of MDRO colonization. The policy revealed enhanced barrier precaution signs were to be posted on the door or wall outside of the resident's room indicating the type of precautions and the personal protective equipment required. Further review of the policy revealed, gowns and gloves should be used during high contact resident care which included, but was not limited to, dressing, bathing/showering, transferring, providing hygiene, changing lines, device care or use, and/or wound care. Review of the facility's Handwashing/Hand Hygiene Policy dated 09/01/1994, with a revision date of March 2022, revealed in part, hand hygiene was indicated immediately before touching a resident, after contact with blood, body fluids, or contaminated surfaces, after touching a resident, after touching the resident's environment, before moving from work on a soiled body site to a clean body site on the same resident, immediately after glove removal. 1.) Resident #6 Review of Resident #6's electronic medical record (EMR) revealed Resident #6 was admitted to the facility on [DATE] with a diagnosis of Gastrostomy status (a surgical inserted tube in the stomach). Observation on 05/13/2024 at 10:00 a.m. revealed Resident #6 had a gastrostomy tube in place. Further observation revealed no evidence of enhanced barrier precautions signage or personal protective equipment in Resident #6's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/15/2024 at 11:10 a.m. S17Licensed Practical Nurse (LPN) entered Resident #6's room to perform gastrostomy tube site care. Observation revealed S17LPN performed site care to Resident #6's gastrostomy tube site without putting on a gown. Observation on 05/15/2024 at 11:12 a.m. revealed S9Wound Care Nurse Licensed Practical Nurse (WCLPN) entered Resident #6's room to provide wound care. Observation revealed S9WCLPN performed wound care to Resident #6's wound without putting on a gown. In an interview on 05/16/2024 at 2:00 p.m. S17LPN confirmed she did not wear a gown when performing Resident #6's gastrostomy site care. S17LPN stated she was unaware Resident #6 was on enhanced barrier precautions. Resident #51 Review of Resident #51's EMR revealed, in part, Resident #51 was admitted to the facility on [DATE] with diagnoses of gastrostomy status, tracheostomy status, acute respiratory failure. Review of Resident #51's Comprehensive Care Plan dated 06/13/2024 revealed, in part, Resident #51 had a suprapubic urinary catheter, gastrostomy tube, and multiple pressure ulcers. Observation on 05/14/2024 at 10:03 a.m. revealed Resident #51 had a suprapubic urinary catheter and a gastrostomy tube in place. Further observation revealed no evidence of enhanced barrier precautions signage or personal protective equipment in Resident #51's room. Observation on 05/15/2024 at 10:40 a.m. revealed S9Wound Care Nurse Licensed Practical Nurse (WCLPN) entered Resident #51's room to provide wound care. Observation revealed S9WCLPN performed wound care to Resident #51's wounds without putting on a gown. Observation on 05/15/2024 at 10:09 a.m. revealed, S10Registered Nurse (RN) performed Resident #51's indwelling urinary catheter care without wearing a gown. Resident #111 Review of Resident #111 electronic medical records (EHR) revealed, in part, Resident #111 was admitted to the facility on [DATE] with the diagnosis of heart failure, chronic respiratory failure unspecified with hypoxia, tracheostomy status, and dependence on respirator (ventilator status). Review of Resident #111 quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/08/2024, revealed, in part, Resident #111 had brief interview of mental status (BIMS) of 15 which indicated Resident #111 was cognitively intact, had active diagnosis of tracheostomy status and dependency on respirator (ventilator status), and had a stage IV pressure ulcer; in which is full thickness tissue loss with exposed bone, tendon, or muscle. Observation on 05/13/2024 at 11:35 a.m., revealed no evidence of enhanced barrier precautions signage or personal protective equipment for Resident #111. Observation on 05/14/2024 at 9:35 a.m., revealed no evidence of enhanced barrier precautions signage or personal protective equipment for Resident #111. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/14/2024 at 9:41 a.m. revealed S9Wound Care Nurse Licensed Practical Nurse (WCLPN) provided wound care to Resident #111's stage IV pressure ulcer with the assistance of S12Certified Nursing Assistant (CNA) without using personal protective equipment. In an interview on 05/14/2024 at 9:41 a.m., S9WCLPN indicated Resident #111 received wound care daily to the stage IV ulcer on her sacrum. Observation on 05/15/2024 at 1:30 p.m. revealed Resident #111's door had no enhanced barrier precaution (EPB) signage. Further observation revealed, S18Respiratory Therapist (RT) performed tracheostomy care to Resident #111, without putting on a gown. Observation on 05/16/2024 at 11:00 a.m. revealed no evidence of EBP personal protective equipment near Resident #111's room. In an interview on 05/16/2024 at 12:35 p.m. S18RT confirmed she did not use a gown when she performed respiratory care on Resident #111 on 05/15/2024. In an interview on 05/16/2024 at 12:45 p.m. S9WCLPN, indicated she did not know anything about enhanced barrier protection. S9 WCLPN also indicated she had not had any training on enhanced barrier protection at the facility. S9WCLPN further confirmed she did not wear a gown when she performed wound care on Resident #111 on 05/14/2024. Resident #474 Review of Resident #474's EMR revealed Resident #6 was admitted to the facility on [DATE] with a diagnosis of respiratory failure, gastrostomy status, and tracheostomy status. Review of Resident #474's May 2024 Physicians Orders revealed, in part an order dated 04/10/2024 for Resident#474's indwelling urinary catheter was to be changed every month and as needed. Observation on 05/13/2024 at 11:47 a.m. revealed Resident #474 lying in bed with an indwelling urinary catheter in place. Further observation revealed no evidence of enhanced barrier precautions signage or personal protective equipment in Resident #474's room. Observation on 05/14/2024 at 11:50 a.m. revealed Resident #474 lying in bed with an indwelling urinary catheter in place. Further observation revealed no evidence of enhanced barrier precautions signage or personal protective equipment in Resident #474's room. Observation on 05/15/2024 at 3:00 p.m. revealed Resident #474 lying in bed with an indwelling urinary catheter in place. Further observation revealed no evidence of enhanced barrier precautions signage or personal protective equipment in Resident #474's room. In an interview on 05/16/2024 at 2:00 p.m. S17LPN stated she was unaware Resident #474 was on enhanced barrier precautions. Resident #475 (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 Resident #475's electronic medical record revealed, in part, Resident #475 was admitted to the facility on [DATE]. Review of Resident #475's Comprehensive Care Plan with a completion date of 05/24/2024 revealed, in part, Resident #475 had an indwelling urinary catheter. Observation on 05/14/2024 at 9:45 a.m. revealed Resident #475 had an indwelling urinary catheter in place. Further observation revealed no evidence of enhanced barrier precautions signage or personal protective equipment in Resident #475's room. Observation on 05/15/2024 at 9:27 a.m. revealed S9Wound Care Nurse Licensed Practical Nurse (WCLPN) preformed Resident #475's wound care without wearing a gown. Observation on 05/15/2024 at 10:25 a.m. revealed, S10Registered Nurse (RN) performed Resident #475's indwelling urinary catheter care without wearing a gown. In an interview on 05/15/2024 at 3:45 p.m., S2Director of Nursing stated Resident #6, Resident #51, Resident #111, Resident #474 and Resident #475 should have had enhanced barrier precautions signage on their door and staff should have used personal protective equipment when performing care and they did not. 2.) Observation on 05/14/2024 at 11:05 a.m., room a revealed a plastic urinal on the hand rail and a plastic wash basin on the floor with no identified label and was not contained. In an interview on 05/14/2024 at 11:05 a.m., S15Licensed Practical Nurse (LPN) confirmed the urinal and wash basin in room a was not labelled and was not contained and should have been. Observation on 05/15/2024 at 10:18 a.m. revealed in room a's bathroom was a plastic urinal on the hand rail and a plastic wash basin on the floor that was not identified and not contained. In an interview on 05/15/2024 at 1:50 p.m., S2DON indicated the urinal and wash basin should have been contained in a plastic bag with the resident's initials identified on these items. 3.) Observation on 05/15/2024 at 10:09 a.m. S10RN entered Resident #51's room to perform gastrostomy tube site care. Observation revealed S10RN removed Resident #51's visibly soiled drainage sponge, obtained a bottle of wound cleanser, applied wound cleanser to gastrostomy tube site, cleaned the gastrostomy tube site, and applied a new drainage sponge to the gastrostomy tube site without performing hand hygiene or changing gloves. Observation further revealed S10RN removed Resident #51's brief, obtained the above mentioned bottle of wound cleanser, applied wound cleanser to Resident #51's suprapubic urinary catheter site, cleaned the suprapubic urinary catheter site, and applied a new drainage sponge to the suprapubic urinary catheter site without performing hand hygiene or changing gloves (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/15/2024 at 10:25 a.m. S10RN entered Resident #475's room to perform gastrostomy tube site care. Observation revealed S10RN removed Resident #475's visibly soiled drainage sponge, obtained a bottle of wound cleanser, applied wound cleanser to gastrostomy tube site, cleaned the gastrostomy tube site, and applied a new drainage sponge to the gastrostomy tube site without performing hand hygiene or changing gloves. Observation on 05/15/2024 at 11:10 a.m. S17LPN entered Resident #6's room to perform gastrostomy tube site care. Observation revealed S17LPN removed Resident #6's visibly soiled drainage sponge, obtained a bottle of wound cleanser, applied wound cleanser to gastrostomy tube site, cleaned the gastrostomy tube site, and applied a new drainage sponge to the gastrostomy tube site without performing hand hygiene or changing gloves. In an interview on 05/15/2024 at 11:30 a.m., S10RN confirmed she did not perform hand hygiene during Resident #51's and Resident #475's gastrostomy tube site care and she should have. S10RN further confirmed she did not perform hand hygiene between performing gastrostomy site care on Resident #51 and changing Resident #51's Suprapubic urinary catheter drainage sponge. In an interview on 05/15/2024 at 11:32 a.m., S17LPN confirmed she did not perform hand hygiene during Resident #6's gastrostomy tube site care and she should have. In an interview on 05/15/2024 at 3:30 p.m., S2DON stated nursing staff should perform hand hygiene after touching a visibly soiled item, prior to touching a clean surface. 4.) Observation on 05/15/2024 at 10:40 a.m. S9WCLPN entered Resident #51's room to perform wound care to Resident #51's right foot. Observation revealed S9WCLPN removed Resident #51's visibly soiled drainage sponge and placed it directly onto his bed. In an interview on 05/15/2024 at 11:15 a.m., S9WCLPN confirmed she placed Resident #51's visibly soiled bandage directly onto his bed. In an interview on 05/15/2024 at 2:00 p.m., S2DON stated the above mentioned findings were against infection control practices and all soiled bandages should be contained. 39158 46683 49753