STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235354	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Health and Rehabilitation	55378 Wilbur Rd Three Rivers, MI 49093

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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care by qualified persons according to each resident's written plan of care. (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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that staff was adequately trained and evaluated for competencies specifically related to administration of Peritoneal Dialysis (PD) (a procedure that removes excess water, solutes, and toxins from the blood in people whose kidneys cannot perform these functions) in 5 (Resident #2, Resident #8, Resident #9, Resident #10, and Resident #11) of 5 residents reviewed for PD, resulting in the potential for unsafe administration of PD, unrecognized complications, increased risk for infection and adverse reactions.Findings include:Resident #2Review of an admission Record revealed Resident #2 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: end stage renal disease (chronic condition where the kidney can no longer function to meet the needs of the body to removed excess water, solutes and toxins) and dependence on renal dialysis. Resident #8Review of an admission Record revealed Resident #8 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: end stage renal disease and dependence on renal dialysis.Resident #9 Review of an admission Record revealed Resident #9 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: end stage renal disease and dependence on renal dialysis.Resident #10Review of an admission Record revealed Resident #10 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnosis which included: end stage renal disease.Resident #11Review of an admission Record revealed Resident #11 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: chronic kidney disease stage 4 and dependence on renal dialysis.In an interview on 7/29/25 at 12:00 pm, Registered Nurse (RN) DD reported the nurses have not received adequate training on how to perform manual exchange PD, use the PD cyclers, or how to manage a dialysis patient. RN DD reported there was a resident who was teaching staff how to do PD. RN DD reported that she used resources such as You Tube to teach herself how to do PD. RN DD reported it was very scary when she performed PD and she didn't feel like she knew what she was doing.In an interview on 7/30/2025 at 12:50 pm, RN DD reported she was shown how to perform PD one time last year.In an interview on 7/30/2025 at 1:02 pm, LPN VV reported she was shown what to do for PD by either another floor nurse or the unit manager.In an interview on 7/30/2025 at 1:05 pm, RN N stated I remember a check list, but I have not received formal training in a way that I feel safe providing PD. We have no idea what we are doing. In an interview on 7/30/2025 at 1:10 pm, Director of Nursing (DON) B stated Our training is what it is. I don't have any experience with dialysis, and I need the instructions to be very clear, and they are not clear.In an interview on 7/30/2025 at 2:10 pm RN R stated I have not had any formal training for administering PD. I was taught how to do PD by Resident #9. RN R stated, I was very uncomfortable and very scared providing PD as I know how careful you have to be with the procedure.In a telephone interview on 7/30/25 at 3:28 pm, Dialysis Registered Nurse (DRN) SS reported the facility had to complete a check list related to dialysis treatments and (Name Omitted) dialysis facility needed to sign off a nurse to perform PD dialysis. DRN SS reported that the dialysis group performs the training sessions. DRN SS reported the facility had super users, but they had been gone from the facility for a couple of months. DRN SS reported that DRN RR was the one that provided the PD training when the facility notified them that they needed new staff to be trained. DRN SS reported there was too much turnover of employees in the facility and stated, I can't sustain training all of them. DRN SS reported he could not recall the last time the facility contacted him regarding training.In a telephone interview on 7/30/25 at 4:07 pm, DRN RR reported she was the nurse who trained the facility staff how to perform PD treatments. Initial training included instructions on a cycler machine and start to finish manual exchange and then the facility would do annual training. DRN RR reported that last time she provided training to facility staff was a couple of months ago. DRN RR reported the facility has a lot of turnovers of employees, and she spoke to DON B when she first started in May 2025 to coordinate a training and DON B suggested waiting until the new assistant director of nursing started. DRN RR reported she had not yet been contacted to schedule a training by DON B.In an interview on 7/31/25 at 8:30 am, Licensed Practical Nurse (LPN) U reported she has been here for about a month and has had no formal training for PD, she has never seen a check list, and has never been evaluated for her knowledge or the process for PD.Review of List of Nurses and Dialysis training dates provided by the facility on 7/30/2025 revealed a list of 26 nurses names and the date the nurse completed dialysis training. Of the 26 nurses' names on the list, 8 nurses had not completed dialysis training

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to 1). implement gait belt use for safety during ambulation (walking) of one resident (Resident #5) and 2). ensure safe transport of a resident in a wheelchair with footrests in place in 1 (Resident #6) of 3 residents reviewed for safety, resulting in the potential for an accident, and/or an injury to occur during ambulation and transport.Findings include:Resident #5Review of an admission Record revealed Resident #5 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: muscle weakness, need for assistance with personal care, and displaced intertrochanteric fracture of the left femur (a break in the thigh bone in the area where hip stability and mobility occurs).On 7/29/25 at 10:11 am, Physical Therapy Assistant (PTA) LL was observed assisting Resident #5 to walk in the hallway between the therapy room and Resident #5's room. PTA LL was not using a gait belt.In an interview on 7/29/25 at 1:13 pm, Therapy Director (TD) MM reported that gait belts should be used with every resident unless they are a mechanical lift. TD MM reported that gait belt use was covered in orientation. TD MM reported any staff who is assisting a resident to walk in the hallway should be using a gait belt for safety.In an interview on 7/29/25 at 1:20 pm, PTA LL reported he was walking Resident #5 in the hallway, and he did not use a gait belt. PTA LL reported Resident #5 was independent in her room and did not require the use of a gait belt. PTA LL stated if I thought she (Resident #5) was going to fall, I would have used a gait belt. I have never used a gait belt when working with her (Resident #5).In an interview on 7/29/25 at 1:28 pm, TD MM reported her expectations were that a gait belt was used when a resident was being assisted to walk in the hallway. TD MM reported Resident #5 being independent in her room had nothing to do with her walking in the hallway.In an interview on 7/29/2025 at 2:05pm, Certified Nurse Assistant (CNA) BB reported that any resident who was being assisted to ambulate needed to have a gait belt on. CNA BB stated they tell you that in orientation.In an interview on 7/29/2025 at 2:18 pm, CNA AA reported a gait belt should be used when ambulating a resident in the hallway.Review of Care Plan for Resident #5 revealed . Focus: The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) h/o (history of) hip fracture, incontinence, weakness. revised on 9/7/023.Goal: Resident will receive assistance with ADLs.revision on 6/26/2025.Interventions: LOCOMOTION: I use a wheelchair for long distance mobility, May use FWW (front wheeled walker) to ambulate to and from bathroom with staff assistance.revision on 9/23/2024.TRANSFER: Usual performance supervision.revision on 6/19/2025.Focus: The resident is at risk for falls.revision on 9/23/2024.Goal: Resident will not sustain serious injury.Revision on 6/26/2025. Interventions: Supervision/touching assist ambulating with walker.revision on 9/23/2024.Review of Quarterly/Annual Nursing UDA Bundle for Resident #5 with a lock date of 6/4/2025 revealed .ADLs- Mobility 8. LOCOMOTION: Self-performance- b. Supervision. 9. WALKING: Self-performance - c. Limited assistance. In an interview on 7/30/2025 at 10:53 am, Director of Nursing (DON) B reported her expectations were that a gait belt was used when ambulating a resident or for any transfer. Resident #6Review of an admission Record revealed Resident #6 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: Alzheimer's disease, muscle weakness, and need for assistance with personal care. Review of a Minimum Data Set (MDS) assessment for Resident #6, with a reference date of 6/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 5/15 which indicated Resident #6 was severely cognitively impaired. (BIMS score 0-7 indicates severe cognitive impairment). On 7/29/25 at 10:15 am, Physical Therapist (PT) KK was observed pushing Resident #6 in her wheelchair down the hall near her room without any footrest in place on the wheelchair. PT KK stated out loud I'm taking her for therapy. PT KK then stopped in the hallway, noted this surveyor, left Resident #6 sitting in the hallway and walked back to Resident #6's room. Resident #6 was observed setting her feet on to the floor. PT KK returned to Resident #6 carrying the footrests for the wheelchair and applied them before continuing down the hallway to the therapy room.In an interview on 7/29/25 at 1:25 pm, PT 'KK confirmed she had pushed Resident #6 without footrest and that she had retrieve Resident #6's footrests from her room as well.In an interview on 7/29/2025 at 1:28 pm, TD MM reported her expectations were that no resident was pushed in a wheelchair without footrests in place.In an interview on 7/29/2025 at 2:05pm, CNA BB reported that any resident who was being pushed in a wheelchair needed to have footrests in place. CNA BB stated they might not keep their feet up when moving.IIn an interview on 7/30/2025 at 10:53 am, DON B reported her expectations were that footrests were in place on resident wheelchairs prior to them being pushed around the building

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure 1). pre and post dialysis treatment assessments were completed; 2). administration of peritoneal dialysis (PD)(a procedure that removes excess water, solutes, and toxins from the blood in people whose kidneys cannot perform these functions) was administered by qualified trained staff; 3). ongoing assessments and/or monitoring were completed during the administration of peritoneal dialysis; 4). ongoing communication between the facility and the dialysis facility (Name Omitted) was documented; and 5). administration of peritoneal dialysis per physician orders occurred for 5 (Resident #2, Resident #8, Resident #9, Resident #10, and Resident #11) of 5 residents reviewed for peritoneal dialysis resulting in the potential for staff being unprepared for a decline in resident condition related to dialysis treatment, unrecognized adverse reactions, and the potential for improper technique/unsafe administration of peritoneal dialysis treatment.Findings include:Resident #2Review of an admission Record revealed Resident #2 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: end stage renal disease (chronic condition where the kidney can no longer function to meet the needs of the body to removed excess water, solutes and toxins) and dependence on renal dialysis.Review of Order Summary for Resident #2 on 7/29/25 revealed .Connect resident to dialysis cycler machine (a machine used to perform peritoneal dialysis) (resident and staff member must wear mask) if weight above 170 pounds use green bag if below 170 pounds use yellow bag. At bedtime every Mon (Monday), Tues (Tuesday), Wed (Wednesday), Thu (Thursday), Sun (Sunday) for PD (peritoneal dialysis) treatment . with a start date of 6/15/25. Daily weights: post PD drain one time a day related to dependent on renal dialysis with a start date of 4/18/25. Disconnect resident from dialysis cycler machine (Resident and staff must wear mask) **Record UF off of machine** (UF- Ultrafiltration refers to the process of removing fluid form the body during the treatment. It is a critical function that helps achieve target dry weight by safely eliminated excess fluid, UF is measured by the amount of fluid removed during a dialysis session) every day shift every Mon, Tue, Wed, Thu, Fri for PD treatment with a start date of 6/16/2025.Drain PD cath (catheter- a surgically placed hollow plastic tube into the lower abdomen used only for peritoneal dialysis treatments) after 12 hour dwell (allowing the dialysis solution to remain in the abdominal cavity) one time a day every Sat (Saturday), Sun for PD with a start date of 6/7/2025. Manual PD exchange: instill 2000ml of warm external solution (purple pull tab) allow to dwell for 12 hours minimum. *VERIFIED RESIDENT COMPLETED* every night shift every Fri (Friday) Sat. with a start date of 6/6/2025.Review of Treatment Administration Record (TAR) for Resident #2 from the date of 6/15/25 through 7/29/25 revealed .No documented weight for 6/23/2025, 6/30/2025, 7/6/2025, 7/17/2025, and 7/23/2025.Review of Medication Administration Record (MAR) for Resident #2 from the date of 6/15/2025 through 7/29/2025 revealed .documented administration of dialysis treatment per the physician order that required a weight to determine bag color on 6/23/25, 6/30/2025, 7/6/2025, 7/17/2025, and 7/23/2025. Further review of Resident #2's MAR revealed no noted documentation of which color bag (yellow, green, or purple) was administered per the physician ordered dialysis treatment on any day between 6/15/2025 and 7/29/2025 that dialysis was administered.During an interview on 7/30/25 at 9:55 am, Registered Nurse (RN) DD reported Resident #2 had been about 170 pounds for so long, the nurses just use that weight when getting the bag of dialysate (the solution used to perform dialysis treatment). RN DD reported Resident #2 should have a daily weight completed per the order. RN DD reported she does not connect Resident #2 to the dialysis cycler machine and never had to document which specific (color) bag was used. RN DD reported she was not able to find any documentation indicating which color bag of dialysate solution was used for each dialysis treatment.Review of Vitals-Weight for Resident #2 from the date of 6/15/25 through 7/29/25 revealed . Resident #2's weights varied from the least amount documented on 7/9/25 of 165.4 pounds to the most amount documented of 188.5 pounds on 7/28/2025. at no time during these dates was Resident #2's weight documented as 170 pounds. In an interview on 7/29/25 at 2:11 pm, Resident #2 reported she doesn't know a thing about her dialysis treatment, the facility does all of it for her.During a telephone interview on 7/30/25 at 3:28 pm, Dialysis Registered Nurse (DRN) SS reported there were three different types of dialysates to be used with the dialysis cycler machine; yellow bag 1.5% which had the lowest amount of dextrose (sugar) and removed the lowest amount of toxins, solutes, and excess water. The green bag 2.5 % had a higher amount of dextrose than the yellow bag, and the red bag 4.25% was the highest amount of dextrose and removed the most amount of toxins

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to properly store narcotic medications in a secure manner resulting in the potential for residents, visitors, and/or staff to access the medication in the facility with a current census of 82 residents. Findings include:On 7/30/2025 at 10:05 am, a plastic medication cup with a name written in black on the side of it, containing a white substance submerged in liquid, was observed sitting on top of the medication cart next to a plastic drinking cup of tan colored liquid in the common area in the secure unit of the facility. At this time there were 7 residents in the room, 1 resident was walking around the room, and 1 CNA was noted to be sitting at a table in the room with her back to the medication cart. No other staff member was present in the room, or near the cart, nor did any staff member have the medication cart or medication within their line of sight.In an interview on 7/30/2025 at 10:10 am, Certified Nursing Assistant (CNA) GG reported that she had nothing to do with medications. When CNA GG was queried regarding the medications that were unattended on the medication cart CNA GG stated I didn't even know there was any medications on the cart.In an interview on 7/30/2025 at 10:20 am, CNA GG reported that Registered Nurse (RN) R was the assigned nurse working the secure unit at this time.On 7/30/2025 at 10:20 am, at 10:30 am, and at 10:41 am, a plastic medication cup with a name written in black on the side of it, containing a white substance submerged in liquid, was observed sitting on top of the medication cart next to a plastic drinking cup of tan colored liquid in the common area in the secure unit of the facility unattended by any staff with residents present in the room and staff and visitors moving in and out of the room.In an interview on 7/30/2025 at 10:30am, CNA HH reported some of the residents that reside in the secure unit wander around the unit and some of them get into things. CNA HH reported that the residents in the secure unit are constantly busy.On 7/30/2025 at 10:42 am, RN R was observed entering the secure unit at the end of the hallway, returning to her medication cart, using a plastic spoon to stir the medication cup with a white substance and liquid in it.In an interview on 7/30/25 at 10:42 am, RN R reported the tan liquid was Med Pass a physician ordered nutritional supplement, and the medication cup with a white substance and liquid in it contained a prescription narcotic medication Lorazepam, an anti-anxiety, schedule IV (4) narcotic medication. RN R indicated that name on the side of the cup did indicate a resident who was present in the common area and that this was this resident's medication that she had not yet administered. RN R stated I never should have left it (the medications) alone and unattended, and I was only off the unit for 15 minutes or so. Direct observation of the unattended medications on top of the medication cart in the common area of the secure unit was from 10:05 am until 10:42 am, a total of 37 minutes.In an interview on 7/30/2025 at 10:52 am Unit Manager/Licensed Practical Nurse (UM/LPN) C reported medications should not be left unattended on the medication cart. When queried about why supplements and dissolved medications should not be left unattended UM/LPN C stated someone could drink it.In an interview on 7/30/2025 at 10:53 am, Director of Nursing (DON) B reported her expectations were that no medication was left unattended on the medication cart ever. The medications should be visualized by the nurse at all times until the medication has been administered and swallowed.Review of facility policy Medication Storage with a reviewed date of 1/3/2025 revealed .a. All drugs and biologicals will be stored in locked compartments.c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.Narcotics and Controlled Substances.a. Schedule II (2) drugs and back up stock of Schedule III, IV, and V (3, 4, and 5) medications are stored under double-lock and key.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer its policies and procedures in a manner that displayed effective and efficient use of resources to attain and maintain the highest practicable physical, mental, and psychosocial well-being for 5 (Resident #2, Resident #8, Resident #9, Resident #10, and Resident #11) of 5 residents reviewed. This deficient practice resulted in 8 staff members administering treatments to Resident #2, Resident #8, Resident #9, Resident #10, and Resident #11, they were neither trained nor qualified to administer.Findings include:Resident #2Review of an admission Record revealed Resident #2 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: end stage renal disease (chronic condition where the kidney can no longer function to meet the needs of the body to removed excess water, solutes and toxins) and dependence on renal dialysis. Resident #8Review of an admission Record revealed Resident #8 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: end stage renal disease and dependence on renal dialysis.Resident #9 Review of an admission Record revealed Resident #9 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: end stage renal disease and dependence on renal dialysis.Resident #10Review of an admission Record revealed Resident #10 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnosis which included: end stage renal disease.Resident #11Review of an admission Record revealed Resident #11 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: chronic kidney disease stage 4 and dependence on renal dialysis.Review of List of Nurses and Dialysis training dates provided by the facility on 7/30/2025 revealed a list of 26 nurses names and the date the nurse completed dialysis (a procedure that removes excess water, solutes, and toxins from the blood in people whose kidneys cannot perform these functions) training. Of the 26 nurses' names on the list, 8 nurses had not completed dialysis training.Review of spreadsheet data provided by the facility on 7/30/2025, involving the dates of 6/15/2025 to 7/30/2025 and including Resident #2, Resident #8, Resident #9, Resident #10, and Resident #11 who received Peritoneal Dialysis (PD), PD (dialysis through the abdominal cavity) procedure type connect/disconnect, and the staff that performed the PD procedure, revealed during the dates of 6/15/25 and 7/30/2025 Resident #2, Resident #8, Resident #9, Resident #10, and Resident #10 received PD treatments 31 times by untrained and unqualified nursing staff.In a telephone interview on 7/30/25 at 3:28 pm, Dialysis Registered Nurse (DRN) SS reported that (Name Omitted) dialysis facility provided new nursing staff and anyone that would work on the floor group training sessions, independent sessions, and any one-to-one that was needed. DRN SS reported the facility had super users; facility employees who had been previously trained and were delegated to train other staff, that were on site and available resources who would provide additional training, but the super users had left the facility a couple of months ago. DRN SS reported he could not recall the last time the facility contacted him regarding training.In a telephone interview on 7/30/25 at 4:07 pm, DRN RR reported she was the nurse who trained facility staff how to perform PD treatments and the last time she provided training to facility staff was a couple of months ago. DRN RR reported she spoke to Director of Nursing (DON) B when she first started at the facility in May 2025 to coordinate a training and DON B suggested waiting until the new assistant director of nursing started. DRN RR reported she had not yet been contacted to schedule a training by DON B.In an interview on 7/31/25 at 8:45 am, DON B stated I have staff that have never been educated or trained on PD, and I am one of them. DON B reported she would not provide PD treatment since she had not been trained and that she was fully aware that she had several nurses who had provided PD and had not been trained.In an interview on 8/4/2025 Nursing Home Administrator (NHA) A reported he had no real knowledge of the Federal regulations regarding dialysis. NHA A reported he knew there was a dialysis den (a separate area where dialysis treatment was performed by an outside provider) within the building, and that he was responsible for managing the finances and life safety of the residents in the building. NHA A stated I have no awareness of what the nurses need or the clinical side of resident care. NHA A stated My responsibility is to make sure they have what they need to care for the residents of the building when queried, NHA A was unable to provide a definition of they within the context of his previous statement. Review of facility policy Peritoneal Dialysis with a reviewed date of 8/1/2025 revealed .This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders to meet the special

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	235354	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Health and Rehabilitation	55378 Wilbur Rd Three Rivers, MI 49093

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. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure proper infection control protocols and practices as evidenced by: 1). The use of personal protective equipment (PPE) during personal care and transfers for 2 (Resident #2 and Resident #7) of 2 residents requiring enhanced barrier precautions, 2. Sanitize resident shared equipment during uses, resulting in increased potential for the spread of infection, bacterial harborage, cross contamination, and disease transmission for residents residing in the facility. Findings include:Resident #2Review of an admission Record revealed Resident #2 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: end stage renal disease (chronic condition where the kidney can no longer function to meet the needs of the body to removed excess water, solutes and toxins) and dependence on renal dialysis.During an observation on 7/29/2025 at 2:00 pm, signage was noted displayed outside of Resident #2's room indicating that Resident #2 was in enhanced barrier precautions (EBP) and that staff should wear PPE (gown and gloves) when performing high contact resident care activities including changing briefs, transfers, and dressing.During an observation on 7/29/2025 at 2:05 pm, Certified Nurse Assistant (CNA) BB was providing peri care and a brief change to Resident #2 in her room and was not wearing a gown.During an observation on 7/29/25 at 2:18 pm, CNA AA joined CNA BB in Resident #2's room and they performed a hoyer (mechanical lift used to move a person from bed to chair or back when they are unable to stand) transfer of Resident #2. Neither CNA AA or CNA BB were wearing PPE, a gown, during the transfer.During an observation on 7/29/2025 at 2:22 pm, CNA AA and CNA BB used the hoyer lift to transfer Resident #2 out of her wheelchair and back to her bed. Resident #2 was suspended in the hoyer lift for several seconds to obtain a mechanical lift weight. Before being laid back down into her bed, while Resident #2 was suspended in the hoyer lift, she began to vomit. Neither CNA AA nor CNA BB were wearing any PPE, gown or gloves, during the transfer. CNA AA and CNA BB were observed applying gloves when Resident #2 reported she was going to get sick and did start vomiting.During an observation on 7/29/25 at 2:28 pm, CNA AA was observed exiting Resident #2 room with the hoyer lift and placing into storage in the beauty salon down the hallway. CNA AA did not clean the hoyer lift prior to leaving it in the beauty salon.In an interview on 7/29/25 at 2:23 pm, CNA BB reported that Resident #2 was in EBP and she should have been wearing PPE during the care she provided to Resident #2, and she was not.Review of Order Summary for Resident #2 revealed .Enhanced barrier precautions: providers and staff must wear gown and gloves for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting. Device care, central line, urinary catheter, tracheostomy. Wound care any skin opening requiring dressing. every shift. With a start date of 2/24/2025.Review of Care Plan for Resident #2 revealed . Resident requires enhanced barrier precautions.initiated on 4/2/2025.wear PPE (gown and gloves).In an interview on 7/29/25 at 2:40 pm, CNA AA reported that the mechanical lifts should be cleaned after each use and CNA AA confirmed she didn't clean the lift before she put it away.In an interview on 7/29/2025 at 2:44 pm, CNA S reported that the mechanical lifts should be cleaned after each use.In an observation on 7/29/25 at 2:49 pm, CNA AA was observed retrieving a container of cleaning wipes, entering the beauty salon, and wiping down the two lifts stored in the room at the time. In an interview on 7/29/25 at 2:53 pm, Registered Nurse (RN) DD reported lifts are not being wiped down by staff, they are placed into a room and stored, not cleaned. Resident #7 Review of an admission Record revealed Resident #7 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: colostomy, need for assistance with personal care, and muscle weakness.In an observation and interview on 7/29/25 at 2:40 pm, CNA AA was observed removing the linen and remaking a bed in the room of Resident #7 and signage was noted outside the door indicating that Resident #7 was in EBP. When queried about the sign posted outside of the room, CNA AA read the sign and stated, I didn't even know what that sign said, I had no idea I was supposed to wear all of this PPE when providing care. During an observation and interview on 7/29/25 at 2:45 pm, CNA XX was in the spa room across from the Director of Nursing office and was assisting with a shower for Resident #7 and CNA XX was not wearing a gown. CNA XX reported she should be wearing PPE to assist Resident #7 with a shower, but there was no PPE available in the spa room for her to use. A tour of the spa room revealed no available PPE, gown or gloves, noted in the spa room.In an interview on 7/29/25 at 2:53 pm, Registered Nurse (RN) DD reported there was no PPE available in the spa room and the staff did