

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235661	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Stonegate Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 Demille Road Lapeer, MI 48446	

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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666</p> <p>Based on observation, interview and record review the facility failed to ensure safe and sanitary storage of respiratory equipment for 3 residents (#3, #272, and #273) and ensure oxygen was provided as ordered for 1 resident (#3) of 3 residents reviewed for respiratory care, resulting in the potential for exposure to infectious organisms for Residents #3, #272 and #273 and inappropriate treatment with potential for adverse reactions for Resident #3.</p> <p>Findings Include:</p> <p>Resident #3</p> <p>Respiratory Care</p> <p>A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #3 was admitted to the facility on [DATE] with diagnoses: Heart failure, chronic respiratory failure, COPD, diabetes, morbid obesity, and obstructive sleep apnea. The resident had a Brief Interview for Mental status/BIMS score of 15/15, indicating full cognitive abilities.</p> <p>On 1/14/2025 at 10:06 AM, Resident #3 was observed lying in bed awake and talkative. He was wearing a nasal cannula with oxygen delivered from an oxygen concentrator. The oxygen was set at 5 liters a minute. When asked what it was normally set at the resident said it should be set at 5. Resident #3 said he had received oxygen for a while and was also receiving Hospice services. A one-gallon bottle of distilled water was approximately 30% empty and sitting on the floor by the bed. It was not dated when opened.</p> <p>A record review of the physician orders identified an order for oxygen at 4 liters via nasal cannula continuously.</p> <p>On 1/16/2025 at 2:30 PM, Resident #3 was observed in his room with his oxygen set at 5 liters a minutes. The resident said that is what he wanted it at.</p> <p>On 1/16/2025 at 4:15 PM, the Director of Nursing/DON was interviewed about Resident #3's oxygen setting of 5 liters/minute, but the physician order said the resident was to receive oxygen at 4 liters/minute. She said she would check into it.</p> <p>(continued on next page)</p>

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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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/16/2025 at 4:45 PM, the DON provided a copy of a physician order for oxygen for Resident #3. The oxygen order was changed on 1/16/2025 at 4:41 PM per the following: Order set O2- Oxygen @ 2-6 L (liters) for comfort per nasal cannula continuous.</p> <p>A review of the facility policy titled, Administration of Oxygen, dated reviewed 12/13/24 provided, Guidelines to properly Administering Oxygen and any Respiratory procedure . 1. Verify physician's order for the procedure . Oxygen setting must be set and adjusted by a licensed nurse .</p> <p>39059</p> <p>Resident #272</p> <p>On 1/14/25, at 2:20 PM, Resident #272 was lying in their bed. Their oxygen concentrator was dialed to 2 liters. Their nasal cannula was lying on the bed covers near the foot of the bed. Resident #272 was asked if they take their oxygen on and off and Resident #272, offered, I don't know.</p> <p>On 1/15/25, at 2:30 PM, a record review of Resident #272's electronic medical record revealed an admission on 01/08/2025 with diagnoses that included Influenza, Acute respiratory failure and Hypertension. Resident #272 required assistance with all Activities of Daily Living.</p> <p>A review of the Physician orders revealed Order Set O2-Oxygen @ 2L (liters) per nasal cannula prn saturation under 93% .</p> <p>A review of the care plan revealed no interventions related to the Oxygen/nasal cannula.</p> <p>Resident #273</p> <p>On 1/14/25, at 11:15 AM, Resident #273 was not in their room. The oxygen concentrator was on and running at 3 liters. The nasal cannula was resting on top of the covers on the bed.</p> <p>On 1/14/25, at 11:30 AM, CNA D entered Resident #273's room and was asked how Resident #273 gets out of bed. CNA D offered, the resident is a Hoyer lift with two staff and is unable to transfer themselves.</p> <p>On 1/15/25, at 2:00 PM, a record review of Resident #273's electronic medical record revealed an admission on 01/06/2025 with diagnoses that included Dementia, Iron deficiency anemia and right leg fracture. Resident #273 required assistance with Activities of Daily Living.</p> <p>A review of the care plan revealed no intervention related to Oxygen/nasal cannula.</p> <p>On 1/16/25, at 8:43 AM, Resident #273 was resting in their wheelchair in their room. Their oxygen was on 3 liters via a nasal cannula. Resident #273 was asked if their oxygen bothers them or if they ever take it off and Resident #273 offered, no, I do not and explained, they might take it down towards their mouth but never takes it off. Resident #273 further explained, the staff always does it when they're helping me in and out of bed.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility provided Administration of Oxygen Approval Date: 5/2018 revealed . a nursing assistant may place the nasal cannula around the resident's ears and in the nose but should not adjust the setting on the concentrator or other administration device . Remove potentially flammable items, wool or nylon materials or other items that may potentiate static from immediate area where the oxygen is to be administered or stored . The facility failed to ensure oxygen supplies were stored in a safe and sanitary manner for R3, R272 and R273.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>49944</p> <p>Based on observation, interview and record review the facility failed to ensure expired supplies were discarded and ensure that medications to be discarded were stored properly, resulting in expired supplies and medications to be discarded being available for use and consumption. Findings include:</p> <p>FACILITY</p> <p>On 01/15/25 at 08:29AM, a review of the 200 Hall medication storage room was conducted and revealed the following expired items:</p> <ul style="list-style-type: none"> -Four boxes of sterile gloves were observed with expiration dates of 09/27/23 and 12/10/23. One box of sterile gloves was unopened and contained fifty pairs, the remaining three boxes were opened and missing pairs of gloves. -One opsite wound dressing was expired as of 4-2024. -Findings were confirmed with the Director of Nursing (DON). <p>On 01/15/25 at 10:27 AM, a review of the 100 Hall medication storage room was conducted and revealed the following expired items:</p> <ul style="list-style-type: none"> -Two push button blood collection sets were observed to be expired as of 02/29/2024. -One winged blood collection kit, expired 01-31-2024. -One culture and sensitivity transfer straw kit, expired 12-2023. -One 22g intravenous catheter, expired 12-01-2024. -These findings were verified with Director of Sales A and Registered Nurse (RN) C. <p>On 01/15/25 at 01:00 PM, a review of the 300 Hall medication storage room was conducted and revealed the following expired items.:</p> <ul style="list-style-type: none"> -12 expired vacutainers for blood draws, expired 12/31/22. -Five normal saline syringes, 10ml, expired 12/08/24 and 12/20/24. -Two non coring needles, expired 9/11/24. -These findings were verified with Licensed Practical Nurse (LPN) B. <p>Review of the policy titled, Medication Storage in the Facility, revised 11/18, revealed:</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Expiration Dating (Beyond-use dating):</p> <p>F. No expired medications will be administered to a resident.</p> <p>G. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner.</p> <p>The policy provided by the facility does not reference the facility procedure for expired supplies.</p> <p>37666</p> <p>FACILITY</p> <p>Medication Administration</p> <p>During a medication administration observation with Nurse H on 1/16/2025 at 8:15 AM, she was observed placing medications for Resident #42 in a medication cup and putting the cup in the top drawer of her medication cart. She said the medications were being held because the resident's vital signs were abnormal and were outside the parameters to give the medications. The nurse was asked what she was going to do with the medications being held and she said that if she had other residents' medications to hold, she would also put them in the cup until she was done passing medications and then she would dispose of them. She said if she had a narcotic to hold, she would also place it in the cup and then find another nurse to witness its disposal after she was finished passing medications. The top drawer of the medication cart was not able to be double locked to store narcotics. Nurse H was asked if this process was approved by the facility and she said, Doesn't it make sense?. Nurse H was asked if the process was documented in the facilities policies, and she said she didn't know but was told this was how it was supposed to be done.</p> <p>On 1/16/2025 at 8:50 AM, Nurse H took the medication cup with the held medications out of the top drawer and said she needed to hold some of Resident #40's medications also. The nurse began adding medications for Resident #40 to the cup and then began removing medications from the cup with her bare hands. She said she wasn't sure if she had the right medications, and she placed several on the top of the medication cart as she tried to identify them with her phone. She then picked up the medications and placed some in the cup to be discarded and some in the cup to give to Resident #40. picking them up with bare hands and placing them into the cup to give to the resident.</p> <p>On 1/16/2025 at 10:00 AM, during an interview with Corporate Nurse K, the medication administration observation with Nurse H was reviewed. She said she would speak to the Director of Nursing/DON immediately and re-education on the appropriate process for medication administration and storage/disposal of held medications would be provided to Nurse H.</p> <p>On 1/16/2025 at 3:00 PM, during an interview with the DON, the medication administration observation with Nurse H was reviewed. She said re-education had been provided to the nurse.</p> <p>A review of the facility policy titled, Medication Storage in the Facility, dated revised 11/18 provided, Medications and biological's are stored safely, securely, and properly . The provider pharmacy dispenses medications in containers that meet regulatory requirements .Medications are kept in these containers .</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>39059</p> <p>Based on observation, interview and record review, the facility failed to ensure that food preferences were followed for one resident (Resident #271) of three residents reviewed for food preferences, resulting in unhappiness and decreased breakfast consumption.</p> <p>Findings include:</p> <p>Resident #271:</p> <p>On 1/15/25, at 9:06 AM, Resident #271 was sitting in their bed with their breakfast tray on their overbed table. There was a sausage patty on their plate. Resident #271 had consumed everything but the sausage. Resident #271 complained they don't like pork and had told them every day. Resident #271 was asked on a scale of 1 to 10 how upset they were regarding the pork on their plate and Resident #271 stated, 5, I don't like it all.</p> <p>On 1/15/25, at 9:10 AM, a record review of Resident #271's meal ticket on their tray revealed . 1/15/2025 Wednesday Breakfast . Dislikes Pork .</p> <p>On 1/15/25, at 12:30 PM, an observation of meal service in the main corridor was conducted. Kitchen staff R was reading the meal tickets and handing the trays out for delivery. Kitchen staff E was asked if they are ensuring dislikes and preferences are followed and Kitchen Staff E offered, yes, the tickets get triple checked.</p> <p>A record review of the facility provided Resident Dining and Food Preferences Effective Date: 11.29.2016 revealed OVERVIEW The Dining services and Clinical Nutrition Support teams have a continued commitment to ensure our residents have the best dining experience possible. One key way to achieve this is through the gathering of resident preferences and the completion of the Resident Dining and Nutrition Preference (DNP) form . Preferences will be obtained on all resident regardless of level of care .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666</p> <p>Based on observation, interview and record review, the facility failed to ensure Infection Prevention and Control standards of practice were followed for 1.) Hand Hygiene during medication administration for 2 residents (#s 40, #42); 2.) Personal Protective Equipment/PPE use for 1 resident (#38) in Transmission Based Precautions; and 3.) storage of resident care items to prevent water splash and contamination from the resident room sink for Resident #22, resulting in the potential for spread of infection, which could cause serious illness.</p> <p>Findings Include:</p> <p>FACILITY</p> <p>Infection Control</p> <p>Resident #22</p> <p>A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #22 was admitted to the facility on [DATE] with diagnoses: history of a stroke, left sided weakness, difficulty swallowing, feeding tube, history of respiratory failure, anxiety, depression, and neuropathy. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status score of 15/15 and she needed assistance with all care.</p> <p>On 1/14/2025 at 9:45 AM, Resident #22 was observed sleeping in bed. She shared a room with another resident and the sink was on her side of the room. The sink countertop was cluttered with open items including a toothbrush (unsure which resident's), an open package with a feeding tube declogger hanging out of the package, many personal items (unsure which resident) and medical supplies for the feeding tube in packages hanging over the sink. There was a graduated cylinder with a small connecting tube with a liquid yellow substance inside it.</p> <p>It was the only sink in the room and there was no way to use the sink to perform hand hygiene without dripping water or encountering a water splash onto the items around the sink.</p> <p>Resident #38</p> <p>A record review of the Face sheet and MDS assessment indicated Resident #38 was admitted to the facility on [DATE] with diagnoses: Diabetes and heart disease. The MDS assessment dated [DATE] revealed the resident had moderate cognitive loss with a BIMS score of 8/15 and needed assistance with care.</p> <p>On 1/16/2025 at 8:00 AM, Resident #38 was observed to have Droplet Precaution and Contact Precaution signs posted outside her room door. A cart with Personal Protective Equipment/PPE was next to the door. The signs instructed anyone who entered the room to wear a mask and isolation gown with gloves prior to entry. Nurse Aide G was observed in Resident #38's room with a surgical mask worn incorrectly under her chin; it was not covering her nose or mouth. She was not wearing an isolation gown or gloves and was taking the resident's vital signs.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When Nurse Aide G exited Resident #38's room, on 1/16/2025 at 8:05 AM, she was asked if Resident #38 was in Transmission-Based Precautions, based on the posted signs and PPE at the door. Nurse Aide G said the resident was not in precautions, that her roommate had been diagnosed with Covid-19 and moved out of the room and the roommate was in precautions. The Nurse Aide was asked about the mask under her chin and she said she wore it just in case she needed it.</p> <p>At 8:06 AM on 1/16/2025, Nurse H was asked if Resident #38 was in Transmission-Based Precautions and she stated, Yes, she is. I have to Covid test her again today. We are ruling out Covid. The Nurse was asked if PPE was required in Resident #38's room and she said it was.</p> <p>Medication Administration</p> <p>Resident #42</p> <p>A record review of the Face sheet and MDS assessment indicated Resident #42 was admitted to the facility on [DATE] with diagnoses: Dementia, diabetes, heart disease, asthma, anxiety and depression. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a BIMS score of 14/15 and needed some assistance with care.</p> <p>On 1/16/2025 at 8:10 AM, during an observation of medication administration with Nurse H, she was observed donning (putting on) gloves to test Resident #42's blood sugar level and removing the gloves and discarding them when she was finished. She did not perform hand hygiene before donning or removing the gloves.</p> <p>During a medication administration observation with Nurse H on 1/16/2025 at 8:15 AM, she was observed placing medications for Resident #42 in a medication cup and putting the cup in the top drawer of her medication cart. She said the medications were being held because the resident's vital signs were abnormal and were outside the parameters to give the medications. The nurse was asked what she was going to do with the medications being held and she said that if she had other residents' medications to hold, she would also put them in the cup until she was done passing medications and then she would dispose of them. She said if she had a narcotic to hold, she would also place it in the cup and then find another nurse to witness its disposal after she was finished passing medications. The top drawer of the medication cart was not able to be double locked to store narcotics. Nurse H was asked if this process was approved by the facility and she said, Doesn't it make sense?. Nurse H was asked if the process was documented in the facilities policies, and she said she didn't know but was told this was how it was supposed to be done.</p> <p>Resident #40</p> <p>During a record review of the Face sheet and MDS assessment for Resident #40, it indicated he was admitted to the facility on [DATE] with diagnoses: End stage kidney disease, diabetes, dialysis, obesity, Crohn's disease, COPD, history of respiratory failure, and anemia. The MDS assessment dated [DATE] the resident had full cognitive abilities with a BIMS score of 14/15 and needed some assistance with care.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/16/2025 at 8:50 AM, Nurse H took the medication cup with the held medications out of the top drawer and said she needed to hold some of Resident #40's medications also. The nurse began adding medications for Resident #40 to the cup and then began removing medications from the cup with her bare hands. She said she wasn't sure if she had the right medications, and she placed several on the top of the medication cart as she tried to identify them with her phone. She then picked up the medications and placed some in the cup to be discarded and some in the cup to give to Resident #40. picking them up with bare hands and placing them into the cup to give to the resident.</p> <p>On 1/16/25 at 11:14 AM, during an interview with the Infection Prevention and Control/IPC Nurse F, she said Resident #38 was in Transmission-Based Precautions and PPE was to be worn in her room. The cluttered sink in Resident #22's room was also reviewed with the IPC and she said she would check on it.</p> <p>On 1/16/2025 at 3:00 PM, during an interview with the DON, the medication administration observation with Nurse H was reviewed, including Nurse H not performing hand hygiene as required and touching the residents' medications with her bare hands. She said re-education had been provided to the nurse.</p> <p>A review of the facility policies identified the following:</p> <p>Infection Prevention and Control Program, dated reviewed 12/17/24 provided, . Purpose: To establish and maintain and 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 .</p> <p>Guideline for Handwashing/Hand Hygiene, review date 12/17/24 provided, . Handwashing is the single most important factor in preventing transmission of infections. Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub . All health care workers shall utilize hand hygiene frequently and appropriately . Health Care Workers (HCW) shall use hand hygiene at times such as: . Before/after having direct physical contact with residents . after removing gloves .</p> <p>Medication Administration-General Guidelines, revised 11/18 provided, Policy: Medications are administered as prescribed in accordance with good nursing principles and practices . Handwashing and Hand Sanitization: The person administering medications adheres to good hand hygiene- before beginning a medication pass, prior to handling any medication, after coming into direct contact with a resident .</p> <p>Guidelines for Droplet Precautions, review date 12/17/24 provided, . To provide precautions when indicated for resident infected with diseases . Examples of infections requiring Droplet Precautions include but are not limited to: . Confirmed/suspected Covid-19 .</p> <p>Guidelines for Contact Precaution, review date 12/17/24 provided, . To provide guidelines to prevent the spread of infectious disease organisms . Contact Precautions is a method designed to reduce the risk of transmission of microorganisms by direct or indirect methods .</p>		