STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265389	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbrook Nursing Center	1101 Hazel Lane Farmington, MO 63640

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to promote and protect the rights of residents, including the right to make choices regarding dining preferences for two residents (Residents #29 and #86) out of 19 sampled residents. This deficient practice had the potential to affect all residents in the facility. The facility's census was 94.The facility did not provide a policy regarding resident dining location and meal choice upon request. Review of the facility's New Hall Tray Menu for Breakfast, undated, showed:-Monday: Biscuits and Gravy, Eggs, Meat;-Tuesday: Eggs, Meat, Toast;-Wednesday: Pancakes, Meat, Eggs;-Thursday: Biscuits and Gravy, Meat, Eggs;-Friday: French Toast, Meat, Eggs;-Saturday: Oatmeal, Toast, Meat, Eggs:-Sunday: Pancakes, Eggs, Meat;-Special Dining Room Only: Monday: Donut, Tuesday: Muffin; Wednesday: Coffee Cake, Thursday: Cinnamon Roll, Friday: Bagel and Cream Cheese, Saturday and Sunday: Cook's Choice.During an interview on 04/01/26 at 3:40 P.M., the Ombudsman Representative said several residents are not pleased with a recent change that took place for breakfast. Currently there is only one menu choice for breakfast; otherwise, the resident has to physically walk to the dining hall to get other menu choices. This causes an inconvenience for several of the residents as many prefer to have breakfast in the privacy of their own room.During an interview on 04/09/26 at 2:12 P.M., Resident #29 said he/she used to eat meals in his/her room but was now required to go to the dining room to receive alternative menu options. Staff would not allow residents to receive alternative options in their rooms. He/She was recently not feeling well and wanted to eat a bowl of soup in his/her room. However, staff told him/her that he/she would have to come to the dining room to receive it. He/She refused, stating, hell no, and reported he/she did not eat that day. Residents should have the right to eat what they want and when they want. Staff told him/her this practice was due to the state not allowing residents to eat in their rooms.During an interview on 04/08/26 at 9:30 A.M., Resident #86 said yesterday he/she was told the facility had changed some of the dining rules. He/She was not happy with the changes. He/She liked to eat in his/her room and was told that if he/she chose to eat in the room, he/she would automatically be given the main entree for each meal and was not allowed to receive any alternative choices from the alternative menu. The only way to receive options from the alternative menu was to eat in the dining room. He/She enjoyed eating in his/her room and did not always like the main meal and would like to have the ability to select alternate options when choosing to eat in the room. Resident #86 reported dissatisfaction with the changes and expressed it was unfair to those that want to eat their meals in their rooms. During an interview on 04/09/26 at 2:36 P.M., Dietary Aide B said dietary aides took the meal orders from the residents dining in the dining room and provided the items requested. Residents who chose to eat in their rooms received the main dish. When asked if residents eating in their rooms could receive an alternate option, Dietary Aide B said no, they received the main dish unless they were sick and needed something such as soup. He/She did not know why residents could not receive alternative options in their rooms, and the change had occurred within the last week.During an interview on 04/10/26 at 9:00 A.M., the Dietary Manager said the facility recently transitioned to a restaurant-style ordering system where residents placed orders in the dining room. Hall trays were only provided with the main dish. This practice was (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265389	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbrook Nursing Center	1101 Hazel Lane Farmington, MO 63640

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implemented to encourage the residents to come to the dining room. Exceptions may be made if a resident was ill. However, these options were not widely advertised. Some residents had been eating all three meals in their rooms and limiting their meal choices encouraged them to come to the dining room. The Dietary Manger said there were some residents that don't like the crowds in the dining rooms and were afraid to eat in there, so he/she has told them she would sit with them to start with to help them to transition to eating their meals in the dining room. He/she provided me a sample of the new breakfast menu which revealed multiple food items labeled dining room only, indicating residents who elected to dine in their rooms were restricted from selecting alternate menu options. During an interview on 04/10/26 at 1:15 P.M., the Administrator and the Director of Nursing said residents should have the right to choose where they dine and what they ate from available menu options. The facility was transitioning to a corporate-directed restaurant-style service model. They had concerns that limiting the residents' ability to choose menu options based on dining location might be a resident rights violation, and the facility would reevaluate the practice and could return to allowing residents to order what they wanted and eat where they chose.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265389	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbrook Nursing Center	1101 Hazel Lane Farmington, MO 63640

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow physician's orders for oxygen (O2) use for two residents (Residents #68 and #80) out of seven sampled residents and one resident (Resident #22) outside the sample. The facility's census was 94.Review of the facility's policy titled, Oxygen Administration, undated, showed:- Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control;- The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders;- Staff shall perform hand hygiene when administering oxygen and or when in contact with oxygen equipment;- Follow manufacturer recommendations for the frequency of cleaning equipment filters, change oxygen tubing and mask/cannula (a device used to deliver oxygen with two small tubes that fit into the nostrils) weekly and as needed if it becomes soiled or contaminated; change humidifier bottle when empty, every 72 hours or as needed, use only sterile water for humidification, if applicable change nebulizer (a medical device that converts liquid medication into a fine mist, allowing it to be inhaled directly into the lungs through a mouthpiece or mask) tubing and delivery devices every 72 hours or per facility policy and as needed if they become soiled or contaminated;- Keep delivery devices covered in a plastic bag when not in use.1. Review of Resident #22's medical record showed:- admitted on [DATE];- Diagnoses of chronic respiratory failure with hypoxia (a condition where the lungs cannot transfer oxygen into the blood), dyspnea (difficulty breathing), and hypoxemia (low oxygen in the blood).Review of the resident's physician order sheet (POS), dated April 2026, showed:- An order to change oxygen (O2) cannula weekly, date and initial, every day shift on Wednesday and Sunday, dated 02/08/26;- An order for supplemental oxygen at two liters per minute (LPM) via nasal cannula (NC) as needed to keep saturations (the percentage of oxygen circulating in the blood) above 90%, dated 11/17/24.Review of the resident's medication administration record (MAR), dated March 2026, showed:- Oxygen tubing not changed on 3/08, 3/22, and 03/29, for a total of three missed opportunities out of eight opportunities.Review of the resident's MAR, dated 04/01/26 to 04/10/26, showed:- Oxygen tubing not changed on 04/05, coded with an (8), see progress notes, and 04/08, for a total of two missed opportunities out of three opportunities;- Oxygen use checked off as administered on day, evening, and night shifts 04/01/26-04/09/26, and on day shift on 04/10/26.Review of the resident's progress note, dated 04/05/26, showed tubing not available, weekend supervisor aware.Observation of the resident showed:- On 04/07/26 at 11:45 A.M., the resident sat upright in his/her bed without oxygen in use, oxygen tubing with NC in a plastic bag, dated 03/11/26, connected to and lay on top of the oxygen concentrator;- On 04/09/26 at 2:18 P.M., the resident lay in bed without oxygen in use, oxygen tubing with NC in a plastic bag, dated 03/11/26, lay on the floor, connected to the oxygen concentrator;- On 04/10/26 at 9:30 A.M., the resident lay in bed without oxygen in use, oxygen tubing with NC in a plastic bag, dated 03/11/26, lay on the floor, connected to the oxygen concentrator.During an interview on 04/10/26 at 9:32 A.M., the resident said that staff changed his/her oxygen tubing every once in a while, and that he/she mostly used oxygen at nighttime.2. Review of Resident #68's medical record showed:- admitted on [DATE];- Diagnosis of congestive heart failure (CHF - a condition where the heart muscle is too weak or stiff to pump blood efficiently, causing fluid buildup in the body).Review of the resident's POS, dated April 2026, showed:- An order for oxygen at two to four liters via NC for shortness of breath, dated 02/19/26;- An order to change oxygen tubing and filter every day shift, every Sunday, dated 02/22/26;- An order for oxygen two liters via NC at hours of sleep (HS) every evening and night shift, dated 02/19/26.Review of the resident's MAR, dated March 2026, showed:- Oxygen tubing not changed on 03/08, 03/22, and 03/29, for a total of three missed opportunities out of five opportunities.Review of the resident's MAR, dated 04/01/26 to 04/10/26, showed:- Oxygen tubing changed on 04/05, with one of one opportunity (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265389	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbrook Nursing Center	1101 Hazel Lane Farmington, MO 63640

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented as completed.- Oxygen use checked off as administered on evening and night shifts for 04/01/26-04/09/26, and on evening shift for 04/10/26.Observation of the resident showed:- On 04/08/26 at 2:15 P.M., the resident sat upright in his/her chair in his/her room with oxygen via NC, oxygen tubing dated 03/15/26;- On 04/09/26 at 2:25 P.M., the resident sat upright in his/her chair in his/her room without oxygen in use, oxygen tubing dated 03/15/26, lay on the floor;- On 04/10/26 at 9:45 A.M., the resident lay in bed with oxygen via NC, oxygen tubing dated 03/15/26.During an interview on 04/08/26, the resident said the staff didn't change his/her oxygen every week.3. Review of Resident #80's medical record showed:- admitted on [DATE];- Diagnoses of CHF and chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that blocks airflow from the lungs, making breathing difficult).Review of the resident's POS, dated April 2026, showed:- An order for continuous supplemental oxygen two to four liters per minute via NC, to keep saturations above 90%, dated 03/31/26;- An order for supplemental oxygen at two liters per minute via NC, to keep saturations above 89%, dated 03/31/26;- An order to change O2 tubing weekly, date and initial, every day shift on Sunday, dated 02/05/26;- An order to change nebulizer tubing and mask weekly, date and initial, every evening shift, every Wednesday, dated 06/16/25.- An order for sodium chloride inhalation nebulization, sodium 3%, inhalant one vial inhale orally via nebulizer two times a day for congestion/thick mucus, dated 09/11/25.Review of the resident's MAR, dated March 2026, showed:- Oxygen tubing not changed on 03/08, 03/22, and 03/29, for a total of three missed opportunities out of five opportunities;- Nebulizer mask not changed on 03/11 and 03/25 coded as an 8, see progress notes; for a total of two missed opportunities out of four opportunities.Review of the resident's progress notes showed:- On 03/11/26, no mask available at this time.- On 03/25/26, nebulizer mask unavailable at this time.Review of the resident's MAR, dated 04/01/26 to 04/10/26, showed:- Nebulizer tubing/mask changed on 04/01 and 04/08 with two of two opportunities documented as completed;- Oxygen tubing not changed on 04/08/26, coded with an 8, see progress notes; for one missed opportunity out of one opportunity.- Review of the resident's progress notes, dated 04/08/26, showed no progress note regarding oxygen tubing.Observation of the resident showed:- On 04/07/26 at 12:30 P.M., the resident sat in his/her chair in his/her room, receiving a nebulizer treatment with the mask dated 02/16/26;- On 04/09/26 at 2:30 P.M., the resident sat in his/her room in his/her wheelchair, a nebulizer mask dated 02/16/26, lay on the bedside table uncovered;- On 04/10/26 at 9:35 A.M., the resident sat in his/her room in his/her wheelchair, receiving a nebulizer treatment with the mask dated 02/16/26.During an interview on 04/10/26 at 11:10 A.M., Certified Medication Technician (CMT) E said day shift CMTs were responsible for changing oxygen tubing weekly on Wednesdays. Oxygen tubing should be changed if found on the floor or if the bag containing the tubing was in the floor. Nurses were responsible for changing nebulizer masks since they were the ones that administered the nebulizer treatments.During an interview on 04/10/26 at 1:15 P.M., the Administrator and the Director of Nursing said they would expect oxygen tubing to be changed and dated per physician's orders, for oxygen to be stored off the floor when not in use, and for the tubing to be changed after touching the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265389	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbrook Nursing Center	1101 Hazel Lane Farmington, MO 63640

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 record review, the facility failed to maintain proper infection control practices during perineal (the area between the genitals and the anus) care for one resident (Resident #95) out of one sampled resident and during wound care for two residents (Residents #4 and #37) out of two sampled residents with a wound. The facility's census was 94.Review of the facility's policy titled, Wound Treatment Management, undated, showed: - Wound treatments will be provided in accordance with physician's orders, including the cleansing method, type of dressing, and frequency of the dressing change; - The policy did not address infection prevention. Review of the facility's policy titled, Infection Prevention and Control, undated, showed: - The facility has established and maintains an infection prevention and control program to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines; - All staff shall assume that all residents are potentially infected and colonized with an organism that could be transmitted during resident care services; - Hand hygiene shall be performed in accordance with the facility's hand hygiene procedures. Review of the facility's policy titled, Hand Hygiene, undated, showed: - All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors; - Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice; - Alcohol based hand rub with 60 to 95 percent (%) alcohol is the preferred method for cleaning hands in most clinical situations; - Wash hands with soap and water when visibly dirty, before eating or after using the restroom; - The use of gloves does not replace hand hygiene. Review of the facility's policy titled, Perineal Care, undated, showed it is the practice of the facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. 1. Observation on 04/09/26 at 1:45 P.M., of Resident #95's perineal care showed: - Certified Nurse Aide (CNA) C and CNA D entered the room, washed hands, and put on gowns and gloves; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265389	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbrook Nursing Center	1101 Hazel Lane Farmington, MO 63640

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	- The resident was rolled toward CNA C and CNA D removed the soiled brief and cleaned the resident's buttocks; - With the same gloves, CNA D placed a clean brief under the resident; - The resident was rolled back toward CNA D, CNA C straightened the clean brief and the resident was rolled onto his/her back again; - CNA D removed gloves, did not wash or sanitize hands, and put on clean gloves; - CNA D cleaned the resident's perineal area; - With the same gloves, CNA D fastened the clean brief and placed pants on the resident; - CNA C and CNA D assisted the resident to reposition in bed; - CNA C and CNA D removed gowns and gloves and washed their hands. During an interview on 04/09/26 at 1:55 P.M., CNA D said he/she should have washed his/her hands before putting on clean gloves, and gloves should be changed between touching dirty and clean areas. 2. Observation on 04/10/26 at 8:40 A.M., of Resident #4's wound care showed: - Licensed Practical Nurse (LPN) A cleared off the resident's bedside table with his/her bare hands, sanitized hands, obtained supplies from the treatment cart, entered the resident's room, and set the supplies on a foam plate on the bedside table; - LPN A obtained a non-skid sock from the resident's drawer and set the sock on the bedside table; - LPN A washed his/her hands and put on a gown and gloves; - LPN A removed the resident's walking boot and, without sanitizing hands, changed gloves; - LPN A obtained scissors from the plate, cut off the old dressing from the resident's left foot, lay the soiled scissors on the resident's bedside table, and threw the old dressing in the trash can; - LPN A, with the same gloves, obtained a medication cup with gauze and Vashe (a wound cleanser) and polymem (a sheet of absorbent wound dressing) and held in his/her left hand while he/she cleansed the wound with the gauze in his/her right hand, and then lay the resident's cleansed leg on the bed sheet with no barrier; - LPN A, with the same gloves, opened a package of Kerlix (rolled gauze dressing) on the plate, obtained the second gauze with Vashe, cleansed the wound, covered with polymem, and wrapped in Kerlix; - LPN A, with the same gloves, cut the Kerlix with the same soiled scissors on the bedside table, and applied the dated and initialed Medipore tape (surgical tape used to secure dressings) to secure the Kerlix; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265389	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbrook Nursing Center	1101 Hazel Lane Farmington, MO 63640

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	- LPN A, with the same gloves, retrieved the non-skid sock from the bedside table, put it on the resident's foot, and reapplied the resident's walking boot; - LPN A, with the same gloves, touched the control pad on the bed frame to lower the resident's bed, touched the resident's call light and bedside table, touched the call light again, and the resident's clothes when clipping the call light to the resident's clothing; - LPN A removed the gown and gloves, put in the trash can, and washed his/her hands; - LPN A retrieved the scissors from the bedside table, obtained gloves and a Sanicloth (a disinfectant wipe) from the treatment cart, put on gloves, sanitized the scissors, wrapped in a paper towel, and placed the scissors in the cart; - LPN A obtained gloves, but did not put the gloves on when he/she removed the old trash bag and put a new trash bag in the trash can, and threw the gloves away in the new trash bag; - LPN A exited the room, threw away the trash in the spa room, and sanitized hands. 3. Observation on 04/10/26 at 11:13 A.M., of Resident #37's wound care showed: - LPN A sanitized his/her hands, put on gloves, retrieved scissors from the treatment cart, lay them on top of the cart, obtained a Sanicloth from the cart, cleaned the scissors, and lay them on a foam plate barrier; - LPN A removed gloves and did not sanitize his/her hands; - LPN A obtained two small medication cups, placed the cups on top of the treatment cart on a foam plate barrier, and added Vashe to each cup; - LPN A obtained 4 x 4 gauze pads and placed them into each medication cup; - LPN A obtained an Aquacel dressing (a sterile dressing that transforms into a gel upon contact with wound drainage), cut it into two pieces, and placed them on top of the foam plate barrier; - LPN A obtained 4 x 4 gauze pads, a gauze wrap, a bordered foam dressing (a sterile, highly absorbent pad), a piece of carboxymethyl cellulose (CMC fiber - a highly absorbent material that turns into gel when it comes into contact with wound drainage), and two pieces of Medipore tape and placed them on the foam plate barrier; - LPN A entered the resident's room and placed the foam plate barrier with the treatment supplies on top of the dresser; - LPN A washed his/her hands, put on a gown and gloves, cut off the soiled gauze wrap, and lay the soiled scissors on top of the dresser; - LPN A removed the soiled dressing from the resident's heel and did not remove gloves nor sanitize hands; - LPN A, with the same soiled gloves, cleansed the heel wound with Vashe and 4 x 4 gauze; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265389	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbrook Nursing Center	1101 Hazel Lane Farmington, MO 63640

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	- LPN A, with the same soiled gloves, added the Aquacel dressing and the bordered foam dressing to the resident's heel; - LPN A removed gloves and did not sanitize his/her hands; - LPN A cleansed the resident's toe area with Vashe and a 4 x 4 gauze; - LPN A, with the same soiled gloves, obtained a piece of CMC fiber and a 4 x 4 gauze, placed on the toe area, wrapped the foot with a gauze bandage, and secured with two pieces of Medipore tape; - LPN A, with the same soiled gloves, obtained a sock from the resident's dresser and placed it on the resident's gauze-wrapped foot; - LPN A removed the gown and gloves and washed his/her hands. During an interview on 04/10/26 at 11:30 A.M., LPN A said he/she should change gloves after removing a soiled bandage and before placing a clean bandage, he/she should sanitize in between glove changes, and should remove soiled gloves before touching resident items. During an interview on 04/10/26 at 1:15 P.M., the Administrator and Director of Nursing said they would expect staff to change their gloves between dirty and clean tasks, to sanitize between glove changes, and to remove dirty gloves before touching a resident's personal items.