STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265400	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooke Haven Healthcare	1410 North Kentucky Avenue West Plains, MO 65775

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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 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 observations, interviews, and record review, the facility failed to assure staff treated five sampled residents (Residents #1, #11, #30, #31, and #39) in a manner that maintained their dignity during mealtimes by standing during meals, assisting multiple residents at a time, and meals being served without assistance available. The facility census was 57.Review of the facility policy titled, Resident Rights, revised December 2016, showed:- Employees shall treat all residents with kindness, respect, and dignity;- Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; c. be free from abuse, neglect, misappropriation of property, and exploitation; d. be supported by the facility in exercising his/her rights. The facility did not provide a policy on dining assistance. 1. Observation on 02/24/26 at 11:40 A.M. to 12:15 P.M., showed:- Certified Nursing Assistant (CNA) D stood to the front and to the right of Resident #58 while he/she sat reclined back in a wheelchair. CNA D used the resident's built-up utensils (modified utensils to assist with independence with eating) to assist the resident to eat. CNA D did not cut up the noodles prior to assisting the resident to eat and the noodles dangled from the spoon and one noodle dropped onto the resident's clothing protector. CNA D picked up the noodle off the clothing protector and sat it on the side of the resident's plate;- CNA E stood to the front and to the right of Resident #11 while he/she sat wheelchair and the wheelchair was not adjusted to fit under the table. CNA E stood over the resident as he/she assisted the resident to eat. CNA E was called away from the dining area at 12:00 P.M., and did not verbalize to the resident his/her departure. CNA E returned to the dining area at 12:08 P.M. and continued to assist the resident to eat while he/she stood over the resident. No staff assisted the resident with eating during CNA E's absence. Staff did not cover the resident's plate or rewarm the food before assisting the resident to eat;- Resident #1 and Resident #31 sat at a dining table with four other residents. Three staff members assisted the other four residents with their meals while Resident #1's and Resident #31's meals sat untouched in front of the residents from 11:45 A.M. to 12:08 P.M. At 12:09 P.M., CNA I stood between Resident #1 and Resident #31 and assisted the two residents with eating. CNA I did not cut up the noodles prior to assisting Resident #31 to eat and the noodles hung off the fork and spoon while CNA I transferred the food from the plate to the resident's mouth. Staff did not cover the residents' plates or rewarm the food before assisting the residents to eat. 2. Observation on 02/24/26 at 11:49 A.M., showed:- Resident #1, Resident #30, and Resident #39 sat at the assisted table in the dining room;- CNA I stood between Resident #1 and Resident #39 and assisted both residents to eat at the same time;- CNA I assisted Resident #30 with eating after his/her meal sat untouched in front of him/her for 20 minutes while CNA I assisted the other residents to eat. Staff did not cover the resident's plate or rewarm the food before assisting the resident to eat. 3. Observation on 02/27/26 at 11:45 A.M., showed:- Resident #1, Resident #30, and Resident #39 sat at the assisted table in the dining room;- CNA D sat between Resident #1 and Resident #30 to assist the residents with eating. CNA D assisted Resident #39's with eating after his/her meal sat untouched in front of him/her for 15 minutes while CNA D assisted the other residents to eat. Staff did not cover the resident's plate or rewarm the food before assisting the (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident to eat. During an interview on 02/24/26 at 12:30 P.M., CNA I said that he/she always stood while assisting to feed residents and fed two residents at a time so not to neglect any of the residents not being assisted with feeding at the time. During an interview on 02/27/2026 at 2:52 P.M., CNA L said he/she normally fed residents by standing up. It was normal to stand up and feed residents. During an interview on 02/27/26 at 5:07 P.M., the Administrator said she would expect staff to assist residents with meals sitting down and should not be standing. During an interview on 02/27/26 at 5:30 P.M., the Director of Nursing (DON) said it was expected for the staff to sit during mealtimes while assisting residents with eating. Also, staff should only assist one resident at a time with eating. During an interview on 02/27/26 at 5:32 P.M., the Assistant Director of Nursing (ADON) said staff should sit down when assisting residents to eat so it would feel homelike for the residents. If residents had food in front of them, she wanted them being fed. During a phone interview on 03/04/26 at 2:29 P.M., CNA E said when assisting with meals or feeding residents, the food should be in front of the resident. Staff should sit and feed or assist the resident. During a phone interview on 03/04/26 at 2:48 P.M., CNA D said when assisting residents in the dining room, staff encourage the residents to eat or then the staff will feed them when needed. Staff were not supposed to stand while feeding the residents and should try to face the resident towards the table. A lot of times the residents faced the staff during assistance with eating.

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to refund resident funds within 30 days of when a resident expired for three residents (Residents #69, #71, and #72) out of three sampled residents and failed to complete a final accounting of resident personal funds within 30 days of discharge for one resident (Resident #70) out of one sampled resident. The facility census was 57.Review of the facility's policy titled, Resident Trust Fund, undated, showed:- When a resident leaves the facility with no plans to return, their Resident Trust Fund (RTF) account must be closed out;- If a resident moves to another nursing facility, it is the responsibility of the office staff to make arrangements to transfer any balance to that resident at the new facility, the office manager will first make sure that no funds are due to the facility for any reason, If there are outstanding balances with the facility, those funds remaining will be considered for use to cover such balances;- If the facility is representative payee for the resident, the facility office staff should contact the local Social Security Administration (SSA) office for directions on how and where to send the close out funds to on behalf of the beneficiary;- All notices to the SSA should happen within 10 days of any resident for whom we are representative payee change within the facility, the office manager is responsible to inform them of any move the resident would make to secure that the social security check is being disbursed to the correct facility, and in any event that our facility would no longer serve as representative payee for a beneficiary;- If a resident passes away, the funds may be considered to cover any past due balance of the beneficiary owed to the facility or any of its related organizations, if a bill is presented from a funeral home for the services of the deceased beneficiary, the facility staff may issue a payment from the resident funds directly to the funeral home, no other funeral expenses may be covered from this account, if there are funds still remaining in the account, and the resident is a Medicaid beneficiary, the funds should be sent back to the Third Party Liability (TPL) unit of the State of Missouri for the Medicaid program using the appropriate submission form completed by the facility staff;- If the facility is representative payee for the deceased resident, all conserved funds must become property of the resident's estate, if an estate is not opened at the time of disbursement, the funds may be sent back to the state of Missouri for all Medicaid beneficiaries;- Any funds received after a resident has been discharged should be returned to the resident, their responsible party, or the sending agency or individual as deemed appropriate by such sender;- If the facility receives conserved funds and benefits for a resident for whom the facility is representative payee, after the resident is discharged from the facility, the funds are to be returned to the SSA local office, the facility office staff should contact the local SSA office for direction on how the funds should be returned, whether by the facility sending those by check to the SSA directly, to another facility directly, or through a recoupment by SSA from our bank account. 1. Review of Resident #69's closed medical record showed:- The resident expired on [DATE]. Review of the facility maintained Resident Trust Fund Ledger, dated [DATE], showed:- Resident #69 had $864.90 held in the resident trust fund account as of [DATE] (806 days late). 2. Review of Resident #71's closed medical record showed:- The resident expired on [DATE]. Review of the facility maintained Resident Trust Fund Ledger, dated [DATE], showed:- Resident #71 had $705.47 held in the resident trust fund account as of [DATE] (660 days late). 3. Review of Resident #72's closed medical record showed:- The resident expired on [DATE]. Review of the facility maintained Resident Trust Fund Ledger, dated [DATE], showed:- Resident #72 had $378.87 held in the resident trust fund account as of [DATE] (469 days late). 4. Review of Resident #70's closed medical record showed:- The resident discharged to another facility on [DATE]. Review of the facility maintained Resident Trust Fund Ledger, dated [DATE], showed:- Resident #70 had $1291.00 held in the resident trust fund account as of [DATE] (29 days late). During an interview on [DATE] at 3:45 P.M., the Administrator said she was responsible for the resident trust fund. She expected the residents to have a final accounting of personal funds and to be provided (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the balance of those funds within 30 days after discharge as per the facility policy. Resident #70 discharged to another facility, but his/her funds deposited after the discharge, and the other residents' balances were overlooked.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a preadmission screening and resident review (PASARR - a federally mandated preliminary assessment to determine whether a resident may have a mental illness or an intellectual disorder and to determine the level of care needed) for one resident (Resident #8) out of two sampled residents and one resident (Resident #52) outside the sample. The facility census was 57.The facility failed to provide a policy regarding the PASRR. 1. Review of Resident #8's medical record showed:- admitted on [DATE];- Diagnoses of stroke, schizoaffective disorder (a condition characterized by abnormal thought processes and deregulated emotions), aphasia (loss of ability to understand or express speech caused by brain damage), depression (a serious medical illness that negatively affects how you feel, think, and act), anxiety (persistent worry and fear about everyday situations), cognitive communication deficit (difficulty in communication), mild cognitive impairment, and vascular dementia with behavioral disturbance (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), dated 11/26/25;- No documentation of the level I and level II PASRR screening completed. 2. Review of Resident #52's medical record showed:- admitted on [DATE];- Diagnoses of schizoaffective disorder and major depressive disorder (long-term loss of pleasure or interest in life);- Determination letter, dated 06/26/17, showed the resident referred for a level II screening and had met the federal definition of serious mental illness and intellectual disability related condition but not require specialized services;- No documentation of the level I and level II PASRR screening completed. During an interview on 02/26/26 at 1:00 P.M., the Administrator said she expected the level I PASRR screening and, if required, the level II screenings be part of the resident record. During an interview on 02/27/26 at 10:37 A.M., the Social Services Director said he/she normally didn't expect to work on the level I or level II PASRR screenings unless a resident admitted from the community. There were no level II PASRR screenings currently on file for any residents in the facility. view J44.9 CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIEDNTA (2 pts)Pulmonary1/27/2022Diagnosis B 1/27/2022ptateview E11.9 TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONSNTA (2 pts)Medical Management1/27/2022Diagnosis C 1/27/2022ptateview R47.01TAPHASIASLPAcute Neurologic1/27/2022Diagnosis D 2/2/2022sblackview F25.9 SCHIZOAFFECTIVE DISORDER, UNSPECIFIED Medical Management1/27/2022Diagnosis E 2/2/2022sblackview F32.A DEPRESSION, UNSPECIFIED N/A, not an acceptable Primary Diagnosis2/16/2026Diagnosis Rank Insignificant 2/16/2026vcallahanview F01.50 VASCULAR DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY N/A, not an acceptable Primary Diagnosis12/1/2025Diagnosis Rank InsignificantDuring Stay1/21/2026twaltonview F01.518 VASCULAR DEMENTIA, UNSPECIFIED SEVERITY, WITH OTHER BEHAVIORAL DISTURBANCE Medical Management11/26/2025Diagnosis Rank Insignificant 11/26/2025hannamcbrideview F41.9 ANXIETY DISORDER, UNSPECIFIED Medical Management4/13/2022Diagnosis Rank Insignificant 4/13/2022ptateview R41.841TCOGNITIVE COMMUNICATION DEFICIT N/A, not an acceptable Primary Diagnosis2/17/2022Diagnosis Rank Insignificant 4/12/2022

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to document the type, the stage, the measurements, and the characteristics of the facility acquired pressure ulcer (areas of localized damage to the skin and/or underlying soft tissue usually over a bony prominence, generally the result of pressure, shear, and/or friction) and also failed to notify and obtain a physician order for one resident (Resident #11) out of one sampled resident with a pressure ulcer. This resulted in Resident #11's stage 1 (intact skin with non-blanchable (discoloration of the skin that does not turn white when pressed) redness of a localized area usually over a bony prominence) pressure ulcer progressing to an open wound. The facility census was 57. Review of the facility's policy titled, Pressure Injury Risk Assessment, dated March 2020, showed:- The purpose of this procedure is to provide guidelines for the structured assessment and identification of residents at risk of developing new pressure injuries or worsening of existing pressure injuries (PIs);- Risk factors that increase a resident's susceptibility to develop or to not heal PIs include, but are not limited to: under nutrition, malnutrition, and hydration deficits, impaired/decreased mobility and decreased functional ability, the presence of previously healed PI, the presence of existing PI, exposure of skin to urinary and fecal incontinence or other source of moisture, altered skin status over pressure points, impaired perfusion, oxygenation or circulation deficits, lower extremity arterial insufficiency, conditions, such as end stage renal disease, thyroid disease or diabetes mellitus, impaired sensory perception, cognitive impairment; and resident refusal of some aspects of care and treatment;- Conduct a comprehensive skin assessment with every risk assessment;- If a new skin alteration is noted, initiate a (pressure or non-pressure) form related to the type of alteration in skin;- Repeat the risk assessment weekly for the first four weeks, if there is a significant change in condition, or as often as is required based on the resident's condition;- Report other information in accordance with facility policy and professional standards of practice. 1. Review of the resident's medical record showed:- admission date of 10/31/25;- Diagnoses of dependence on renal dialysis (a treatment that filters waste and excess fluid from your blood when your kidneys are failing), type one diabetes mellitus (a disease that occurs when your body makes little or no insulin), pain, major depressive disorder (MDD - long term loss of pleasure or interest in life), anxiety disorder (persistent worry and fear about everyday situations), gastro-esophageal reflux disease (GERD - stomach acid being forced back into the throat region), end stage renal disease (when the kidneys are no longer able to work at a level needed for day-to-day life), spinal stenosis of the lumbar region (narrowing of the spinal canal in the lower back, specifically in the lumbar region), and dystonia (a movement disorder that causes the muscles to contract). Review of the resident's Physician Order Sheet (POS), dated February 2026, showed:- An order for Triad Paste (barrier cream) to the buttocks every shift, dated 12/31/25;- An order to turn every two hours while in bed. Due to open wounds, the resident is to be the last resident up for meals and the first one down after meals following a 30-minute period after eating to prevent aspiration (when something other than air gets into the airways, often something that's supposed to be in your stomach, like food, liquid, or stomach contents), every shift, dated 11/11/25;- No order for weekly skin assessments;- No order for a dressing or instructions for treatment of the bandage to the sacrum (the large, triangle-shaped bone in the lower spine that forms part of the pelvis);- No order for a pressure ulcer treatment. Review of the resident's Treatment Administration Record (TAR), dated February 2026, showed:- Triad Paste to buttocks every shift, dated 12/31/25;- Turn every two hours while in bed. Due to open wounds, resident is to be the last resident up for meals and the first one down after meals following a 30-minute period after eating to prevent aspiration every shift, dated 11/11/25;- No orders and documentation for skin and/or wound assessments;- No orders and documentation for pressure ulcer treatments;- No documentation of the type, the stage, the measurements, and the characteristics of the open wound to the resident's sacrum from 02/22/26 - 02/27/26. Review of the resident's Weekly Skin Check Assessments, dated 01/06/26 - 02/24/26, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed:- On 01/06/26, Licensed Practical Nurse (LPN) B documented a sacrum pressure ulcer/injury with non-blanchable erythema (abnormal redness) of intact skin;- On 01/13/26, LPN B documented no new skin issues found on this evaluation. Sacrum stage 1 pressure ulcer/injury with non-blanchable erythema of intact skin;- On 01/27/26, LPN B documented no new skin issues found on this evaluation. Sacrum stage 1 pressure ulcer/injury with non-blanchable erythema of intact skin;- On 02/24/26, LPN B documented no new skin issues found on this evaluation. Sacrum stage 1 pressure ulcer/injury with non-blanchable erythema of intact skin;- No documentation of weekly skin check assessments completed for 01/20/26, 02/03/26, 02/10/26, and 02/17/26;- The facility failed to complete weekly skin assessments for four missed out of eight opportunities. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by the facility), dated 02/19/26, showed:- Severe cognitive impairment;- Dependent for all ADLs and mobility;- Always incontinent of bowel and bladder;- No pressure ulcer/injury;- At risk for pressure ulcer;- No unhealed pressure ulcers/injuries;- No other ulcers, wounds, or skin problems;- Pressure reducing device for chair and bed. Review of the resident's Braden (a tool used to assess a patient's risk of developing pressure ulcers) Scale, dated 02/23/26, showed:- Very limited sensory perception;- Occasionally moist;- Chairfast;- Resident is very limited and makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently;- Probably inadequate nutrition;- Problem with friction and shear;- Score: 12.0 which indicates the resident is a high risk for skin breakdown. Review of the resident's Care Plan, revision date 02/17/26, showed:- The resident dependent on staff for all activities of daily living (ADL);- Always incontinent of bowel and bladder and poor cognitive ability;- Pressure injuries present upon admission to the facility with interventions of: - Assess/record/monitor wound healing weekly; - Pressure relieving device on his/her bed and in his/her wheelchair; - Two hour turn and two hour reposition while up in a chair; - Follow facility policies/protocols for the prevention/treatment of skin breakdown; - Provide treatment to the area to the buttocks as ordered; - Report worsening, and signs/symptoms of infection or non-healing; - Did not address the resident's stage 1 pressure ulcer on the sacrum. Observation of the resident's incontinent care on 02/25/26, showed:- At 1:58 P.M., Certified Nursing Assistant (CNA) D performed incontinent care;- A 2 inch (in.) x 2 in. bordered foam dressing to the sacrum, dated 02/22/26, with the outside of the dressing brown in color and three sides unattached to the resident's skin. Observation of the resident on 02/25/26 at 3:02 P.M., showed:- LPN H pulled back the brown discolored dressing, dated 02/22/26, from the resident's sacral area;- The dressing had a black, dry substance on the inside which covered a nickel size open area with a white substance on the open wound;- The resident had fecal matter in his/her brief and LPN H put the same soiled dressing back in place to cover the wound, exited the room, and alerted CNAs the resident needed incontinent care.During an interview on 02/25/26 at 4:15 P.M., Licensed Practical Nurse (LPN) G said Resident #11's current treatment consisted of Triad cream to the buttocks every shift, and off-load to reduce pressure. He/She was not aware of any new skin concerns being reported for the resident but would expect it to be reported to the nurse if one was found. During an interview on 02/27/26 at 4:36 P.M., LPN B said staff had been putting a bordered gauze dressing on the resident's sacrum for protection due to it being a sensitive area and had been an open wound before. On 02/24/26, he/she completed a skin assessment, did not remove and/or change the bordered dressing, and did not assess if the resident's sacrum was open. He/She passed on in report to the oncoming nurse the dressing was not changed. During an interview on 02/27/26 at 5:07 P.M., the Administrator said if there was a wound found during care, the staff should notify the charge nurse, the Director of Nursing (DON) or the Assistant Director of Nursing (ADON), and the physician should be contacted. She would expect a resident to have a new dressing be applied to the wound and not the old dressing be put back on until after incontinent care was provided to the resident. During an interview on 02/27/26 at 5:32 P.M., the ADON said if a soiled dressing was found during incontinent care, staff should remove the soiled dressing and notify the nurse immediately for a redressing. She assessed the resident's wound after (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it was identified this date as opened and he/she would stage it as at least a stage 2 (damage to the skin that results in the loss of the outermost layer of and exposure of the middle layer of skin) but he/she didn't stage the wound because that was a physician's scope of practice. She said the wound care company completed the wound measurements, but she did it if the wound care company was unable to. All skin issues should be reported to the nurse or directly to her so it can be assessed, physician notified, and an order be given if needed. During a phone interview on 03/04/26 at 3:18 P.M. LPN K said he/she put the bordered foam dressing on the stage 1 to the resident's sacrum for extra protection on 02/22/26. The resident didn't have an order for the dressing, and he/she didn't notify the physician, the DON, or the ADON of the stage to the resident's sacrum. He/she didn't know if the dressing was changed or the stage 1 assessed after he/she placed the dressing on 02/22/26. He/She should have reported the stage 1 to the ADON and wasn't for sure if he/she notified the oncoming shift nurse of the stage 1 and the dressing. LPN K checked the resident's skin on the weekends, and applied the Triad Paste, but the wound opened quite frequently. LPN K said he/she did not document the dressing being placed, did not notify the physician, and did not obtain an order for the dressing. During a phone interview on 03/10/26 at 3:50 P.M., the Physician said he/she would expect staff to report redness or any other skin issues to the nurse, and the nurse to report it to the physician. There should be a physician's order to put a dressing on a resident. He/She would expect the nurse to document when he/she contacted the physician regarding a resident. For Resident #11, he/she would not have covered the area and would have expected the resident's skin to be assessed at a minimum of every shift if staff placed a dressing on a resident. He/She believed skin assessments were expected every shift. During a phone interview on 03/17/26 at 10:07 A.M., the ADON said the nurses were responsible for completing skin assessments weekly and charting them. If there were any skin issues, they should be brought to her attention and then she would contact the provider and refer to the wound care provider. LPN B would have been responsible for completing the weekly skin assessments for Resident #11 on 01/20/26, 02/03/26, 02/10/26, and 02/17/26. During an interview on 03/17/25 at 11:02 P.M., LPN B said he/she did the skin assessments on paper, and they were transcribed into the computer later. The nurse who did the skin assessment was to document it in the computer. There were days he/she did not have time to put them into the computer. If he/she was unable to put the assessment into the computer, it went to the DON or ADON to be entered. In the last couple months, he/she didn't remember not putting any weekly skin assessments into the computer, but there might have been a handful not entered.

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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 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. Based on observation, interview, and record review, the facility failed to ensure proper storage of nasal cannulas (plastic tubing placed in the nostrils to provide supplemental oxygen) when not in use for two residents (Residents #4 and #38) and failed to follow oxygen orders for two residents (Residents #38 and #52) out of four sampled residents. The facility census was 57.Review of the facility's policy titled, Oxygen Administration, revised October 2010, showed:- Verify there is a physician's order for this procedure;- Review the physician's orders or facility protocol for oxygen administration;- Assemble the equipment and supplies as needed;- Place appropriate oxygen device on the resident (i.e., mask, nasal cannula and/or nasal catheter);- Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered;- Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened, be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through;- Did not address proper storage of the nasal cannula. 1. Review of Resident #4's medical record showed: - admission date of 05/23/22;- Diagnoses of chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), systolic congestive heart failure (CHF - an inability of the heart to pump sufficient blood flow to meet the body's needs). Review of the resident's Physician Order Sheet (POS), dated February 2026, showed:- An order for oxygen at 2-4 liters per minute (L/min) per nasal cannula continuously due to shortness of breath and maintain oxygen saturation (measures the percentage of oxygen-carrying hemoglobin in the blood, indicating how well oxygen is being delivered to the tissues) above 90 percent, dated 01/19/26. Observation of the resident on 02/24/26 at 11:27 A.M., showed: - The resident lay in bed with the oxygen concentrator on at 2.5 L/min at the bedside;- The resident's nasal cannula, dated 02/21/26, lay on the floor and the prongs touched the floor;- The resident's oxygen saturation was 89 percent without oxygen;- The nasal cannula for the portable oxygen tank, undated, hung from the wheelchair brake without a sealed container. Observation of the resident on 02/24/26 at 2:23 P.M., showed: - The resident lay in bed with the oxygen concentrator on at 2.5 L/min at the bedside;- The resident's nasal cannula, dated 02/21/26, wrapped around his/her forehead;- The nasal cannula for the portable oxygen tank, undated, hung from the wheelchair brake without a sealed container. Observation of the resident on 02/25/26 at 3:36 P.M., and 02/26/26 at 4:02 P.M., showed: - The resident lay in bed with the oxygen concentrator on at 2.5 L/min at the bedside;- The nasal cannula, dated 02/21/26, lay under the resident's sheet; - The nasal cannula for the portable oxygen tank, undated, hung from the wheelchair brake without a sealed container. Observation of the resident on 02/27/26 at 8:45 A.M., showed: - The resident lay in bed with the oxygen concentrator on at 2.5 L/min at the bedside and with the nasal cannula in place;- The nasal cannula for the portable oxygen tank, undated, hung from the wheelchair brake without a sealed container. 2. Review of Resident #38's medical record showed:- admission date of 10/17/25;- Diagnosis of acute and chronic respiratory failure with hypoxia (a sudden, dangerous worsening of breathing in a patient with an existing, long term lung disease). Review of the resident's POS, dated February 2026, showed;- An order for oxygen continuously to maintain oxygen saturations above 90 percent, dated 02/09/26. Observation of the resident on 02/24/26 at 1:55 P.M., showed:- The resident lay in bed with the oxygen concentrator on at 3 L/min at the bedside;- The nasal canula, dated 02/21/26, was sideways on the resident's face and inserted in only one nostril;- The nasal cannula for the portable oxygen tank, undated, lay in the floor without a sealed container. Observation of the resident on 02/26/26 at 8:28 A.M., and 4:04 P.M., showed:- The resident lay in bed with the oxygen concentrator on at 3 L/min at the bedside;- The nasal cannula for the portable oxygen tank, undated, lay in the floor without a sealed container. Observation of the resident on 02/27/26 at 8:29 A.M., 12:09 P.M., 1:51 P.M., and 5:55 P.M., showed:- The resident lay in bed with the oxygen concentrator off at the bedside;- The nasal cannula attached to the oxygen concentrator, undated, lay in the floor without (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a sealed container;- The nasal cannula for the portable oxygen tank, undated, lay in the floor without a sealed container;- The resident did not have oxygen on as ordered. During an interview on 02/27/26 at 8:30 A.M., Resident #38 said he/she didn't know why the concentrator was off, but it was turned off a while ago. 3. Review of Resident #52's medical record showed:- admission date of 03/14/25;- Diagnoses of COPD and unspecified systolic CHF. Review of the resident's POS, dated February 2026, showed:- An order for oxygen as needed, resident may self-maintain, oxygen via nasal cannula to maintain oxygen saturation above 90 percent, dated 11/21/25;- An order to check oxygen saturation daily due to diagnosis of COPD, dated 07/19/25;- An order to titrate oxygen as needed to maintain saturation above 90 percent, dated 01/20/25; - An order for portable oxygen via nasal cannula for when resident is not in room, may titrate to maintain oxygen saturation above 90 percent, dated 01/20/25. Observation of the resident on 02/24/26 at 2:18 P.M., showed:- The resident lay in bed with the oxygen concentrator on at 2.5 L/min at the bedside;- The nasal cannula, dated 02/21/26, hung coiled outside of a container from the nightstand drawer;- No portable oxygen supplies were available. During an interview on 02/24/26 at 2:18 P.M., Resident #52 said he/she could use the portable oxygen for trips outside his/her room to the dining area and other areas of the facility. Staff had mentioned providing the portable equipment, but he/she hadn't heard anything else lately. Observation of the resident on 02/25/26 at 2:29 P.M., showed: - The nasal cannula, dated 02/21/27, hung coiled outside of a container from the nightstand drawer;- The resident was outside of the room. Observation of the resident on 02/26/26 at 8:23 A.M., and 02/27/26 at 1:51 P.M., showed: - The resident lay in bed with the oxygen concentrator on at 2.5 L/min at the bedside and with the nasal cannula, dated 02/21/26, in place;- No portable oxygen supplies were available. During an interview on 02/27/26 at 2:19 P.M., Licensed Practical Nurse (LPN) B said the residents should have their oxygen on as ordered. The nasal cannula should be in the resident's nose and not on their forehead. The concentrator should be on the correct L/min as ordered. If the nasal cannula wasn't on the resident, it should be placed back on them. The oxygen was checked by a certified nursing assistant (CNA). If the portable oxygen was not in use, the cannulas should be placed in a bag. The oxygen saturation should be checked if they were not wearing the oxygen. During an interview on 02/27/26 at 2:27 P.M., LPN A said the storage bags should be dated, but not the nasal cannula. The portable nasal cannula should never be on the floor. The tubing should be placed in a bag when not in use. During an interview on 02/27/26 at 2:34 P.M., CNA N said when checking on a room with oxygen, there should be a bag on the concentrator for placing the nasal cannula in and it should not be on the floor. The nasal cannula should be changed out weekly and should be aligned properly in the resident's nose. The portable oxygen nasal cannula on a wheelchair should be in a bag. The oxygen order should be followed and if it was for continuous oxygen, it should be on all the time. During an interview on 02/27/26 at 2:39 P.M., CNA M said the oxygen concentrator should be checked to see if it was on and the nasal cannula should be positioned and aligned with the nostrils. The nasal cannula for portable oxygen should be coiled up and stored in a bag. The nasal cannula should not be on the floor. The nasal cannula should be dated with staff initials. If there was an order for continuous oxygen, it should be on the resident. During an interview on 02/27/26 at 2:52 P.M., CNA L said the nasal cannula should be aligned in the nose properly and connected. The portable oxygen should have a gauge, and the nasal cannula should be in a plastic storage bag. The resident should be wearing it all the time if the order was for continuous oxygen. During an interview on 02/27/26 at 5:07 P.M., the Administrator said oxygen orders should be followed. The CNA should let the charge nurse know if there were problems. During an interview on 02/27/26 at 5:32 P.M., the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) said residents with oxygen should be checked. If the residents weren't wearing the nasal cannula, their oxygen saturation level should be checked. If it was low, the resident needed to be encouraged to put the nasal cannula on. If the oxygen saturation was good and in range, the nasal cannula should be stored in a plastic bag on the concentrator. If the nasal cannula was on the floor, it should be changed.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. :Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than five percent (%). There were 25 opportunities with two errors made, resulting in an error rate of 8% for two residents (Residents #13 and #54) out of seven sampled residents. The facility's census was 57.Review of the facility's policy titled, Administering Medications, revised April 2019, showed:- Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so;- Medications are in accordance with prescriber orders, including any required time frame;- Insulin pens containing multiple doses of insulin are for single resident use only;- Insulin pens are clearly labeled with the resident's name or other identifying information. Prior to administering insulin with an insulin pen, the nurse verifies that the correct pen is used for that resident;- Each nurse's station has manufacturer's instructions or user's manuals related to any medication administration devices kept with the devices or at the nurses' station. Review of the insulin aspart (a rapid insulin injected just below the skin that helps lower mealtime blood sugar spikes) Flex Pen (insulin in a pen-type device) instructions, revised July 2023, showed:- To prime the pen, turn the dose knob to select two units;- Hold the pen with the needle pointing up. Tap the cartridge holder gently to collect airbubbles at the top;- Continue holding the pen with the needle pointing up. Push the dose knob in until it stops, and number zero is seen in the dose window. Hold the dose knob in and count to five slowly;- Insulin should be seen at the tip of the needle. If you do not see insulin, repeat the steps;- Turn the dose knob to select the number of units you need to inject and administer the insulin. 1. Review of Resident #13's Physician Order Sheet (POS), dated February 2026, showed:- An order for insulin aspart Pen subcutaneous (an injection just below the skin) inject 6 units plus sliding scale before meals. Sliding scale for blood sugars of 181-220 = 4 units, 221-260 = 6 units, 261-300 = 8 units, 301-350 = 10 units, 351-400 = 12 units, if blood sugar is 140 or below no sliding scale just 6 units, dated 09/17/25.Observation of the resident's insulin administration on 02/27/26 at 10:35 A.M., showed:- Licensed Practical Nurse (LPN) B administered six units of insulin aspart subcutaneously as ordered for a blood sugar of 140 with the resident's insulin aspart Pen;- LPN B failed to prime the insulin aspart Pen per the manufacturer's instructions prior to the administration to the resident.2. Review of Resident #54's POS, dated February 2026, showed:- An order for insulin aspart Pen inject 12 units subcutaneously before meals, dated 12/20/25.Observation of the resident's insulin administration on 02/27/24 at 10:30 A.M., showed;- LPN B administered six units of insulin aspart subcutaneously as ordered with the resident's insulin aspart Pen;- LPN B failed to prime the insulin aspart Pen per the manufacturer's instructions prior to the administration to the resident. During an interview on 02/27/26 at 4:20 P.M., LPN B said he/she had recently moved from out of state and in the previous state he/she lived in, they did not prime insulin pens. During an interview on 02/27/26 at 5:20 P.M., the Administrator said she expects staff to follow policy and procedure regarding insulin administration. During an interview on 02/27/26 at 5:25 P.M., the Assistant Director of Nursing (ADON) said it was expected to prime the insulin pens with two units of insulin. During an interview on 02/27/26 at 5:30 P.M., the Director of Nursing (DON) said it was expected the staff prime insulin pens by wasting two units of insulin before administering the full dose.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement enhanced barrier precautions (EBP) and follow appropriate infection control practices with hand hygiene and glove changes when staff performed wound care for three residents (Residents #2, #20, and #58) out of four sampled residents, and during incontinent care for three residents (Residents #11, #31, and #58) out of four sampled residents. The facility also failed to correctly screen three residents (Residents #20, #51, and #68) for tuberculosis (TB - an infectious disease characterized by the growth of nodules in the tissues, especially the lungs) out of five sampled residents as required by state regulation 19 CSR 20-20.100. The facility census was 57. Review of the facility's policy titled, Wound Care, dated October 2010, showed:- Wipe nozzles, foil packed, bottle top, with alcohol before opening;- Use disposable cloth to establish clean field on resident's overbed table;- Wash and dry hands thoroughly;- Wash and dry hands after removing dressing and glove again;- Be certain all clean items are on clean field;- Wipe reusable supplies with alcohol as indicated. Review of the facility's policy titled, Enhanced Barrier Precautions, dated August 2022, showed:- EBP are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDRO) to residents;- EBP employs targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply;- Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room);- Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.), and wound care (any skin opening requiring a dressing). Review of the facility's policy titled, Personal Protective Equipment - Using Gloves, revision dated September 2010, showed:- Wash hands after removing gloves. Note: Gloves do not replace handwashing. Review of the facility's policy titled, Screening Residents for Tuberculosis, dated August 2025, showed:- This facility shall screen all residents for TB infection and disease. Individuals identified with active TB disease shall be isolated from other residents and ancillary staff, and transported to an appropriate care facility as soon as possible;- The admitting nurse will screen referrals for admission and readmission for information regarding exposure to or symptoms of TB;- Screening of new admissions or readmissions for TB infection and disease is in compliance with State regulations. Review of the facility's policy titled, Cleaning and Disinfection of Resident Care Items and Equipment, date revised October 2018, showed:- Resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection and the Occupational Safety and Health Act (OSHA) bloodborne pathogens standard. 1. Observation of Resident #58's incontinent care on 02/24/26 at 11:13 A.M., showed:- EBP signage on the door;- Certified Nursing Assistant (CNA) E and CNA F entered the room, did not perform hand hygiene, put on gloves, and did not put on a gown;- CNA E used a disposable wipe to clean fecal material from the resident's buttocks with the same area of the disposable wipe two times instead of using a clean area of the disposable wipe with each wipe, changed gloves, and performed hand hygiene;- CNA F removed the wet incontinent pad from under the resident, did not change gloves, did not perform hand hygiene, touched the closet handle, touched the resident's clean shorts, touched the drawer handle, touched the clothing inside the drawer, removed gloves, did not perform hand hygiene, and exited the room;- CNA F reentered the room, did not perform hand hygiene, did not put on a gown, put on gloves, and assisted CNA E with the transfer of the resident to the wheelchair. 2. Observation of Resident's #58's wound care on 02/24/26 at 11:40 A.M., showed:- EBP signage on the door;- Licensed Practical Nurse (LPN) B gathered supplies, entered the room, and put supplies on the resident's dresser without a clean barrier;- LPN B did not perform hand hygiene, put on gloves, and did not put on a gown;- LPN B (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removed resident's shoe and sock, did not perform hand hygiene, did not change gloves, cleaned the open wound to the resident's right heel with gauze saturated with wound cleanser, did not change gloves, and did not perform hand hygiene;- LPN B opened the skin prep wipe, wiped the surrounding skin of the open wound, did not change gloves or perform hand hygiene, opened and placed a bordered foam dressing (a type of dressing) to the open wound on the right heel, did not change gloves or perform hand hygiene, and placed the sock and shoe on the resident's right foot. 3. Observation of Resident #31's incontinent care on 02/25/26 at 1:41 P.M., showed:- CNA D and CNA E entered the room, performed hand hygiene, put on gloves, and transferred the resident from the wheelchair to the bed;- CNA E removed gloves, performed hand hygiene, and exited the room;- CNA D removed the resident's urine saturated pants and dropped them on the floor, did not change gloves or perform hand hygiene, used a disposable wipe to clean the outer left leg, covered the urine-soaked resident with bed linens, changed gloves, and performed hand hygiene;- CNA E entered room with disposable wipes, did not perform hand hygiene, and put on gloves;- CNA D unfastened and removed the resident's urine saturated brief and did not change gloves or perform hand hygiene;- CNA D placed a clean brief at the resident's buttock area and the brief touched the resident's skin soiled with urine;- CNA D assisted the resident to turn on his/her back, cleaned the resident's middle groin with the same area of the disposable wipe three times. CNA D retrieved a clean disposable wipe, cleaned the left side of the groin with the same area of the disposable wipe six times, and with a new area of the same wipe, cleaned the right side of the groin with the same area of the disposable wipe seven times. CNA D did not change gloves, did not perform hand hygiene, assisted the resident to turn to the side, cleaned the resident's right rear thigh and buttock with the same area of the disposable wipe six times, changed gloves, and performed hand hygiene;- CNA E fastened the urine soiled brief and did not change the urine soiled incontinent pad from under the resident;- CNA E and CNA D used the soiled incontinent pad to reposition the resident in bed, and CNA D covered the resident with the urine soiled bed linens. 4. Observation of Resident's #11's incontinent care on 02/25/26 at 1:58 P.M., showed:- EBP signage on the door;- CNA D performed hand hygiene and put on a gown and gloves;- CNA D cleaned the resident's left groin with the same area of a disposable wipe three times, cleaned the left groin with another area of the of the disposable wipe two times, retrieved a new disposable wipe and cleaned the upper middle groin area, did not clean the lower groin area, did not change gloves, and did not perform hand hygiene;- CNA D used the incontinent pad to turn the resident onto the right side, cleaned the buttocks, the sacrum (a large, inverted triangular bone at the base of the lumbar spine) had a dressing discolored brown and dated 02/22/26, removed the brief soiled with fecal material, did not change gloves, and did not perform hand hygiene;- CNA D placed a clean brief under the resident, pulled the resident's pants up, removed gloves, did not perform hand hygiene, and touched the bed control. 5. Observation of Resident #11 on 02/25/26 at 3:02 P.M., showed:- EBP signage on the door;- LPN H entered the room, did not perform hand hygiene, put on gloves, and did not put on a gown;- LPN H unfastened and lowered the resident's brief and exposed the resident's dressing on his/her sacrum;- LPN H pulled back the brown discolored dressing, dated 02/22/26, from the resident's sacrum;- The dressing had a black, dry substance on the inside which covered a nickel size open area with a white substance on the wound;- The resident had fecal matter in his/her brief and LPN H put the same soiled dressing back in place over the wound, removed the gloves, performed hand hygiene, exited the room, and went to get staff to perform incontinent care. 6. Observation on 02/27/26 at 8:05 A.M., of Resident #20's wound care showed:- EBP signage on door;- LPN A gathered supplies; entered the room; put the bandage supplies on a clean tray on the bed; put scissors, a box of gloves, wound cleanser, and tape on the resident's bed without a clean barrier; exited the room; and pushed the resident into the room in a wheelchair from the dining room;- LPN A did not perform hand hygiene, put on gloves, and did not put on a gown;- LPN A sprayed gauze with wound cleanser and cleaned the wounds to the left lower leg, did not perform hand hygiene, and did not change gloves; - LPN A sprayed gauze with a wound cleanser and cleaned the wounds to the right lower leg; - LPN A lay the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	soiled gauze on the floor;- LPN A changed gloves, did not perform hand hygiene, picked up the scissors off of the resident's bed, cut the calcium alginate (a type of wound dressing) with scissors, placed the calcium alginate on the open wounds to the left leg, did not change gloves, and did not perform hand hygiene;- LPN A put Xeroform (a type of wound dressing) on the open wounds to the right leg, did not change gloves, and did not perform hand hygiene;- LPN A put Kerlix (gauze bandage roll) around the left leg, did not perform hand hygiene, did not change gloves, put an ABD (large absorbent dressing) pad and a gauze roll around the right leg, did not perform hand hygiene, and did not change gloves;- LPN A picked up the trash off the floor and threw it away;- LPN A removed gloves, performed hand hygiene, and pushed the resident back to the dining room;- LPN A placed the wound cleanser, tape, scissors, and a box of gloves from the resident's bed into the treatment cart without sanitizing them. 7. Observation on 02/27/26 at 8:20 A.M., Resident #2's wound care showed:- EBP signage on the door;- LPN A gathered supplies, entered the room, put the supplies on a clean tray on the bedside table, and placed the soiled scissors used during Resident #20's wound care on the bedside table;- LPN A did not perform hand hygiene and put on a gown and gloves;- LPN A removed the dressings from the resident's right hip, left hip, and the sacrum;- LPN A did not perform hand hygiene, did not change gloves, cleaned the left hip wound, did not perform hand hygiene, did not change gloves, applied Xeroform, applied a border gauze, did not perform hand hygiene, and did not change gloves;- LPN A rolled the resident to the left side, cleaned the right hip wound, sat the wound cleanser bottle on the resident's bed without a clean barrier, did not perform hand hygiene, and did not change gloves;- LPN A cleaned the sacrum wound, did not perform hand hygiene, did not change gloves, applied metronidazole powder (an antibiotic medication) to the right hip wound, inserted calcium alginate with silver rope (a type of wound care treatment) with a cotton applicator, covered with a sterile gauze pad cut with the soiled scissors, sat the scissors on the resident's bed without a clean barrier, secured the gauze pad with a border gauze, did not perform hand hygiene, and did not change gloves;- LPN A placed metronidazole and calcium alginate with silver rope into the sacral wound, covered with border gauze, did not perform hand hygiene, and did not change gloves;- LPN A moved the wound cleanser bottle and scissors from the bed to a bookcase; - LPN A removed gloves and gown, performed hand hygiene, exited the room, put the scissors and wound cleanser bottle into the treatment cart without sanitizing them. 8. Review of Resident #20's medical record showed;- admitted on [DATE];- Step one Tuberculosis Skin Test (TST), dated 01/08/26, with a result of 0 millimeters (mm) and no read date;- Step two TST, dated 01/22/26, with a result of 0 mm and no read date. 9. Review of Resident #51's medical record showed:- admitted on [DATE];- Step one TST, dated 01/12/26, with a result of 0 mm and no read date;- Step two TST, dated 01/26/26, and no result. 10.Review of Resident #68's medical record showed:- admitted on [DATE];- Step one TST, dated 02/20/26, with a result of 0 mm and no read date. During an interview on 02/25/26 at 4:15 P.M., LPN G said hand hygiene should be performed upon entering and exiting a resident's room, when moving from dirty to clean task/care, gloves should be changed when moving from dirty to a clean task. EBP consisted of a gown and gloves and should be worn while providing care when a resident had wounds, catheters, ports (a central line that gives medicine and fluid into your veins), intravenous line (IV - a soft, flexible tube placed inside a vein), tracheostomy tube (a hollow tube that goes through the hole and into your windpipe to help you breathe), or a gastrostomy tube (G-tube - a tube inserted through the abdomen that brings nutrition directly to the stomach). When performing incontinent care, clean front to back, use one wipe and throw it away or fold it over to a clean area. Soiled items should not be placed on the floor, they should be put in a bag and taken to soiled utility, then hands should be washed. During an interview on 02/26/26 at 3:57 P.M., LPN B said should perform hand hygiene before and after resident care, after disposing of soiled linens and trash, and between dirty and clean tasks. Should put on gloves after hand hygiene and change gloves between dirty and clean tasks. EBP was to wear a gown and gloves when doing in contact direct care, such as incontinent care, and dressing changes on residents with wounds and/or lines, drains, or tubes not (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 - Few	naturally occurring from the resident's body. Incontinent care should be completed front to back and include the genitals. Should not use the same area of the wipe multiple times. Should wipe, fold, wipe, dispose of wipe, and use a new wipe until the area was clean. During an interview on 02/27/26 at 5:07 P.M., the Administrator said she would expect staff to follow policy and procedures regarding maintaining infection control during care to include handwashing, glove changes, wound care, and such. It was expected that staff complete resident TST per policy and procedures. During an interview on 02/27/26 at 5:32 P.M., the Assistant Director of Nursing (ADON) said staff should wear a gown and gloves for care for those residents who were on EBP protocol. Staff should sanitize hands before care, with glove changes, at the end of care, and anytime they question if they needed to, or their hands became visibly soiled. Glove changes should occur when moving from one area of the body to another or moving from soiled to clean during care, or if gloves become visibly soiled. Supplies should be placed on a barrier and sanitized in between residents if used for more than one. Scissors should be sanitized between wounds and residents. Trash and discarded wound care items should not be placed on the floor. It was expected that staff complete resident TST per policy and procedures. During an interview on 02/27/26 at 5:52 P.M., the Director of Nursing (DON) said staff should follow policy and procedure for infection control, handwashing, glove changes, wound care, and basic standards. Trash should not be placed on the floor. EBP policies should be utilized for care for those residents on it. It was expected that staff complete resident TST per policy and procedures. During a phone interview on 03/04/26 at 2:29 P.M., CNA E said hand hygiene should be completed upon entering the resident's room, then put on gloves, perform care, remove gloves, perform hand hygiene, and then perform hand hygiene again at the nurse's station after disposing of soiled items and trash. Hand hygiene with glove changes going from dirty to clean tasks. Soiled items should not be on the floor, they should be placed in a trash bag. When performing incontinent care, it should be one swipe per wipe and throw it away. EBP consisted of using a gown and gloves during care for a resident with a wound, catheter, or peripherally inserted central catheter (PICC - a thin, flexible tube that delivers treatments through a vein) line. During a phone interview on 03/04/26 at 2:48 P.M., CNA D said hand hygiene should be performed when you enter a resident's room, with glove changes, and when finished up with care. Change gloves and perform hand hygiene when moving from a dirty to clean task or area. When performing incontinent care, use a new cloth with each wipe. EBP consisted of the gown and gloves and should be used when providing care for a resident with open wounds, active infection, or an IV. During a phone interview on 03/04/26 at 3:04 P.M., CNA F said should perform hand hygiene and put on gloves when going into a room, change gloves and perform hand hygiene when moving from dirty to clean care, and perform hand hygiene before leaving the room. Soiled items go in a bag, not on the floor. When performing incontinent care, get a new wipe with each wipe. EPB was wearing gown and gloves to protect the resident with open wounds, catheters, and IVs.