STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265581	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingdom Care Senior Living LLC	811 Center Street Fulton, MO 65251

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37131 Based on observation, interview and record review, facility staff failed to provide a clean, safe, and comfortable home-like environment when staff failed to adequately maintain doors and keep walls in resident rooms free of gouges in the drywall and scrapes in the paint. The facility census was 26. 1. Review of the facility's policy titled Quality of Life-Homelike Environment, dated May 2017, showed residents are provided with safe, clean, comfortable and homelike environment. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting, to include clean, sanitary and orderly environment. 2. Review of the facility's policy titled Maintenance Service, dated December 2009, showed the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel include maintaining the building in compliance with current federal, state, and local lows, regulations, and guidelines. The building should be maintained in good repair. The Maintenance Director is responsible for developing and maintaining a maintenance schedule. A copy of the maintenance schedule shall be provided to each department director so that appropriate scheduling can be made without interruption of services to the residents. The Maintenance Director is responsible for maintaining Work Order Requests. 3. Observation on 09/09/24 at 10:51 A.M., showed resident occupied room [ROOM NUMBER] drywall and paint peeled from the floor to the ceiling, an unpainted patched circular area, behind the sink in the bathroom had unpainted patched drywall, and the bathroom door contained black scrape marks on the lower quarter of the door. 4. Observation on 09/09/24 at 11:01 A.M., showed occupied room [ROOM NUMBER] a hole in the drywall had been patched with drywall mud and had not been painted. Drywall behind headboard of bed is damaged and missing paint. The wall beneath the thermostat in the room had a hole in the drywall and areas of chipped paint. The dresser in the room and door to the bathroom had chunks of wood and the finish missing. The heater in the restroom leaned out of the wall and base trim is off the wall behind the toilet. 5. Observation on 09/09/24 at 11:33 A.M. showed in occupied room [ROOM NUMBER] the wall behind bed A had unpainted drywall. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Observation on 09/09/24 at 12:05 P.M. showed in occupied room [ROOM NUMBER] two visible unpainted patches of drywall on the right side of the bed. 7. Observation on 09/09/24 at 2:15 P.M., showed in occupied room [ROOM NUMBER] the wall behind and alongside bed A and the wall behind and alongside bed B had several areas of unpainted drywall. To the left of the window on the far wall of the room there are black marks on the lower portion of the wall. The back corner of the room had decorative bricks stacked two high underneath the head of bed B. 8. Observation on 09/09/24 at 2:15 P.M., showed in occupied room [ROOM NUMBER] the wall to the left side of the window had several areas of unpainted drywall. The wall on the right side of the room behind bed B and recliner has several gouges and areas of unpainted drywall. 9. Observation on 09/09/24 at 2:42 P.M., showed in occupied room [ROOM NUMBER] damage to drywall and paint scraped off of the wall behind the headboard of a bed. 10. Observation on 09/09/24 at 2:51 P.M., showed in occupied room [ROOM NUMBER] the wall to the left of the entrance alongside bed A had several areas of unpainted drywall. 11. Observation on 09/10/24 at 9:34 A.M., showed in occupied room [ROOM NUMBER] had damaged drywall and paint under wall thermostat and above chair in room. 12. Observation on 09/10/24 at 10:05 A.M., showed in occupied room [ROOM NUMBER] had missing paint and damaged drywall on wall beside bed and on wall beside window. During an interview on 09/12/24 at 10:47 A.M., Certified Nurse Aide (CNA) J said staff are supposed to tell the nurse if they see something that needs fixed. The CNA said staff should report damaged walls and doors to the nurse and the nurse should put a work order in the computer for maintenance. The CNA said he/she is usually too busy trying to take care of the residents to look at cosmetic stuff. During an interview on 09/12/24 at 10:49 A.M., Registered Nurse (RN) H said staff should tell him/her if there is damage to walls and doors and he/she will send an email to the Maintenance Director. The RN said he/she has noticed damage to walls, walls with drywall mud on them and unpainted. The RN said he/she did not send a maintenance request when he/she noticed because he/she is uncertain if someone else had already reported it. During an interview on 09/12/24 at 10:54 A.M., the Maintenance Director said staff are supposed to send him/her a work order if something needs repaired. He/She said if repairs are needed in a resident room he/she has to have a work order before entering the room. The Maintenance Director said he/she tries to respond to concerns within 24 hours. The Maintenance Director said he/she doesn't think he/she has gotten any work orders for walls or doors in resident rooms this week. The Maintenance Director said the aides are rough and tear up the walls with the beds. The Maintenance Director said he/she doesn't have a set schedule to paint the patched drywall damage. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/12/24 at 11:03 A.M., the administrator said staff is supposed to notify maintenance when they see damage to walls and doors. The administrator said aides should tell the nurses and the nurses should email maintenance. The Administrator said they put paper requests at the nurses station, so even aides could fill out a maintenance request. The administrator said he/she has not noticed drywall repairs that had not been painted. The administrator said he/she has educated staff on reporting maintenance issues. 45489 50361

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50361 Based on observation, interview, and record review, facility staff failed to update the care plans for meal assistance for two residents (Resident #3 and #24) and for bed rail usage for one resident (Resident #3) of 19 sampled residents. The facility census was 26. 1. Review of the facility's policy titled, Care Plans, Comprehensive Person-Centers dated, December 2016 says; -The interdisciplinary team should develop and implement a comprehensive, person-centered care plan for each resident, -The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment, -Care plans will include the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, -Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 2. Review of Resident #3's care plan dated, 10/14/23, showed staff documented the resident independent with meals after setup assistance, and required assistance from two staff member for bed mobility. Review showed the care plan did not contain documentation in regard to the resident's side rail use and meal assistance. Review of the resident's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 06/24/24, showed the resident required set-up assistance for eating and has upper extremity impairment of one side. Review of the resident's physician orders, dated 09/2024, showed an order may use a transfer bar to the bed for self-positioning. Observation on 09/09/24 at 10:42 A.M., showed the resident had a partial contracture of his/her right hand and used his/her left hand to eat finger foods. Observation on 09/09/24 at 12:16 P.M., showed the resident in the dining room for the noon meal. Observation showed the resident struggled to use a fork with his/her left hand and could not obtain a bite of food. Observation on 09/09/24 at 12:29 P.M., showed the dietary director approached the resident in the dining room and offered him/her a bite. The resident took the bite and the dietary director walked away. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/09/24 at 12:35 P.M., Certified Nurse Aide (CNA) I approached resident and asked if he/she is okay but did not offer to assistance the resident with his/her meal. During an interview on 09/09/24 at 12:50 P.M., the resident said he/she is hungry and had a hard time eating because of his/her left hand. The resident said he/she is right-handed but is not able to use the right hand to eat. Observation on 09/09/24 at 2:50 P.M., showed two quarter bed rails up on both sides of the resident's bed. Observation on 09/11/24 at 12:22 P.M., showed dietary staff served the resident lunch and placed the silverware on the right-hand side of the plate. The resident struggled to reach across his/her plate for the silverware. Staff brought drinks to the resident and placed the drinks on the right-hand side of the resident's plate out of the resident's reach. During an interview on 09/12/24 at 9:55 A.M., CNA I said staff are supposed to supervise the resident during meals and offer assistance as needed. The CNA said he/she knows the resident has limited use of his/her right hand and is right-handed. CNA I said the resident is usually pretty good at using his/her left hand. CNA I said staff should not place silverware or drinks on the resident's right side. CNA I said the resident uses the bed rails to hold on when being turned from side to side. The CNA said this should be on the resident's care plan. During an interview on 09/12/24 at 10:21 A.M., Registered nurse (RN) H said mealtime assistance needs should be on the care plan but the RN does not have time to look at the care plans so he/she did not know if it is on the resident's care plan. RN H said the resident has days when he/she required more assistance and that is why he/she is sat in the assisted dining room. RN H said staff should offer to help the resident if he/she is struggling. RN H said staff know the resident does not use his/her right hand due to a contracture and that the resident is right handed. RN H said staff should not put the resident's items like drinks or silverware on his/her right side because it puts the items out of the resident's reach. RN H said the resident uses the bed rails to help turn in bed with staff assistance. RN H said the resident can not use the bed rails independently and they should be care planned. During an interview on 09/12/24 at 10:48 A.M., the Director of Nursing (DON) said the MDS coordinator is responsible for care plan development but he/she is out on leave, so the DON has been updating the care plan. The DON said the resident's meal time assistance needs should be care planned and he/she did not know why it had not been. The DON said the bed rails are called positioning rails and the resident uses the rails with staff assistance while turning. The DON said this should be in the resident's care plan. 3. Review of Resident #24's quarterly MDS, dated [DATE] shows staff assessed the resident choked and coughed while he/she ate. Review of the resident's care plan, dated 05/29/24, showed staff documented the resident is independent with eating. The care plan did not contain intervention for the residents choking concerns. Review of the resident's nutrition assessment, dated 07/22/24, showed the resident required nectar thick liquids with supervised assistance meals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 09/09/24 at 12:26 P.M., showed dietary staff served the resident his/her meal and fed the resident. Observation on 09/11/24 at 11:28 A.M., showed dietary staff served the resident drinks without additional staff present in the dining room. Staff served a meal enhancement shake in the original container. Observation showed the resident coughed and choked while he/she drank the shake. Dietary staff took the drink and thickened it in a separate glass. The resident continued to drink nectar thick fluids and coughed and choked. Dietary staff served the resident his/her meal without additional staff present and the resident coughed and choked while he/she tried to eat his/her meal. During an interview on 09/12/24 at 10:01 A.M., CNA I said the resident receives nectar thick liquids because he/she has difficulty swallowing. The CNA said the resident should not be along in the dining room without supervision while eating or drinking. The CNA said the resident could choke if left unsupervised. The CNA said the resident's swallowing issues and need for supervision should be on his/her care plan. During an interview on 09/12/24 at 10:27 A.M., RN H said the resident has swallowing issues and is working with speech therapy. The resident requires nectar thick liquids. RN H said there should be a nursing staff member present in the dining room if the resident is eating or drinking. The RN said if nursing staff is not present the resident could choke while eating or drinking. The RN said the resident's swallowing issues and need for supervision should be on his/her care plan. During an interview on 09/12/24 at 10:54 A.M., the DON said the resident does have occasional issues with swallowing and requires nectar thick liquids. The DON said nursing staff should be in the dining room if the resident has food or drinks. The DON said if nursing staff is not present in the dining room the resident could choke on their food or drinks. The DON said the resident's swallowing issues and need for supervision should be on his/her care plan. During an interview on 09/12/24 at 11:33 A.M., the administrator said there should be a care plan for the resident's swallowing issues and interventions staff are implementing. The administrator said nursing staff should always be in the dining room if the resident is eating or drinking.

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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. 50361 Based on observation, interview, and record review, facility staff failed to obtain a physician's order for and failed to update the plan of care for one resident (Resident #23) out of two sampled residents who received oxygen therapy. The facility census was 26. 1. Review of the facility's policy titled, Oxygen Administration, dated October 2010, showed staff are directed to verify there is a physician's order. Review the physician's order or facility protocol for oxygen administration. Review the care plan to assess for any special needs of the resident. 2. Review of Resident #23's admission Minimum Data set (MDS), a federally mandated assessment tool, dated 07/07/24, showed staff assessed the resident used oxygen. Review of the resident's Physician Orders Sheet (POS), dated September 2024, showed it did not contain an order for oxygen. Review of the resident's care plan, dated 07/07/24, showed staff documented the resident used oxygen continuously. Review showed staff documented the resident is unable to propel self and manage the oxygen concentrator. Review of the resident's progress notes, dated July 2024, showed staff documented: -On 07/2/24: Resident in a recliner with oxygen set at three liters (L) via nasal cannula (NC); -On 07/3/24: Residents oxygen saturation (the percentage of hemoglobin in the blood that is saturated with oxygen compared to the total amount of hemoglobin in the blood) is 95% on three liters of oxygen via NC; -07/28/24: Residents oxygen saturation is 97% on three liters of oxygen via NC. Observation on 09/09/24 at 11:30 A.M., showed the resident in the dining room and oxygen at five liters via NC. Observation on 09/11/24 at 10:52 A.M., showed the resident with four liters of 4L of oxygen via NC. Observation on 09/12/24 at 10:06 A.M., showed the resident four liters of oxygen via NC. During an interview on 09/12/24 at 9:58 A.M., Certified Nurse Aide (CNA) I said the resident receives continuous oxygen at two to three liters per minute. He/she said all nursing staff is responsible for checking the oxygen setting but the nurse is responsible for adjusting it. CNA I said when the resident is transported within the facility they take the concentrator with him/her. CNA I said oxygen use should be on the resident's care plan. He/she said they would go to the nurse for instruction if it is not on the care plan. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/24 at 10:25 A.M., Registered Nurse (RN) H said the resident receives three to four liters per minute of oxygen when at rest. RN H said there should be an order for oxygen, and it should also be in the resident's care plan. During an interview on 09/12/24 at 10:51 A.M., the Director of Nursing (DON) said the resident's oxygen concentrator should be set at two liters per minute when resident is at rest. He/she said staff should find this on the resident's care plan as well as physician's orders. He/She said he/she did not know the resident's oxygen had been set at four or five liters per minute. The DON said the resident's oxygen is only for comfort and when he/she is not ambulating for transport, he/she does not need it. The DON he/she is responsible for ensuring oxygen is listed on the physician's orders and the care plan since the Assistant Director of Nursing is out on leave. During an interview on 09/12/24 at 11:31 A.M., the administrator said oxygen use should have a physician's order and it should be on the care plan. The administrator said there was some confusion and changes with the resident's oxygen when he/she first admitted .

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 45489 Based on observation, interview, and record review, facility staff failed to post the required nurse staffing information, which included the total number of staff and the actual hours worked, by both licensed and unlicensed nursing staff directly responsible for resident care, per shift, and on a daily basis. The facility census was 26. 1. Review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, dated August 2022, showed staff were directed to do the following: -Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents; -Within two hours of the beginning of each shift, the number of licensed nurses (Registered Nurses (RN), Licensed Practical Nurses (LPN) and the number of unlicensed nursing personnel (Certified Nurse Aides (CNA) and Nurse Aides (NA) directly responsible for resident care is posted in a prominent location accessible to resident and visitors and in a clear and readable format; -The information on the form shall include the following: -Twenty-four hour shift scheduled operated by the facility; -Type (RN, LPN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift who are paid by the facility; -The actual time worked during that shift for each category and type of nursing staff; -Total number of licensed and non-licensed nursing staff working for the posted shift; -Within two hours of the beginning of each shift, the charge nurse or designee computes the number of direct care staff and completes the Nurse Staffing Information form; the charge nurse completes the form and posts the staffing information in the location(s) designated by the administrator. 2. Observation on 09/09/24 at 11:09 A.M., showed the daily nurse staff posting did not include the number of licensed staff or the total number of hours worked for the evening shift (3 P.M. to 11 P.M.) and night shift (11 P.M. to 7 A.M.). Observation on 09/10/24 at 8:45 A.M., showed the daily nurse staff posting did not include the number of licensed staff or the total number of hours worked for all three shifts. Observation on 09/11/24 at 8:02 A.M., showed the daily nurse staff posting listed only licensed staff for the day shift (7 A.M. to 3 P.M.), and did not include the total number of hours worked for the day shift or staff and total number of hours worked for the two remaining shifts. Observation on 09/12/24 at 12:47 P.M., showed the daily nurse staff posting did not include licensed staff or the total hours worked for all three shifts. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	3. During an interview on 09/12/24 at 7:56 A.M., Licensed Practical Nurse (LPN) L said he/she puts the form out every night, and each shift charge nurse fills out staffing numbers and hours per shift. LPN L said he/she did not know the form is not being filled and staff just forget. LPN L said he/she turns the forms in to the Administrator each night. He/she was not sure who is responsible for ensuring the forms are completed, but they are given to the Administrators office. During an interview on 09/12/24 at 10:35 A.M. the Director of Nursing (DON) said the daily nurse staff posting should be completed during report, and should have licensed staff and total hours for all shifts. The DON did not know the form is not being filled out. He/She said the oncoming charge nurse is responsible to fill it out at the beginning of each shift, he/she said it has always been filled out for each shift separately, and staff will need education about filling it out completely. He/she said the forms are turned in to the office at night and he/she believes the administrator is responsible for reviewing. During an interview on 09/12/24 at 1:19 P.M., the administrator said daily nurse staff posting should have the census, the number of staff, and the hours worked for each shift. The charge nurse on the floor is responsible for filling out the form for the whole day. The administrator did not know the form is not being filled out during the day. The administrator said the DON should be monitoring when doing floor rounds to ensure the forms are completed accurately for the whole day.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37131 Based on observation, interview, and record review, facility staff failed to implement Enhanced Barrier Precautions (EBP) to prevent the spread of bacteria and other infection causing contaminants during the provision of care for two residents (Residents #9 and #28) of a sample of two residents. The facility census was 26. 1. Review of the facility's titled Enhanced Barrier Precautions, undated, showed EBP are an infection control intervention designed to reduce the transmission of Multidrug-Resistant Organisms (MDROs) in nursing homes. EBP expands upon Standard Precautions by requiring the use of gowns and gloves during specific high-contact resident care activities. High-contact resident care activities are activities that have been demonstrated to result in the transfer of MDROs to hands or clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. Example of high-contact care activities include, but are not limited to dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of catheter, feeding tube, etc. The Infection Preventionist ensures that regular audits of staff adherences to EBP guidelines are conducted. Any deviations from protocol should prompt additional training and education efforts. 2. Review of Resident #9's Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/02/24, showed staff assessed the resident had a severe cognitive impairment and required a feeding tube. Review of the resident's Physician Order Sheet (POS), dated September 2024, showed an order for enteral feedings every shift by feeding tube. Observation on 09/09/24 at 11:53 A.M., showed the resident received his/her tube feeding in his/her room. Observation showed outside the resident room did not contain an EBP sign posted outside the resident's room or Personal Protective Equipment (PPE) station observed inside or outside the resident's room. Observation on 09/09/24 at 3:15 P.M., showed the resident's feeding tube leaked and ran down the front of the resident's shirt. Licensed Practical Nurse (LPN) D entered the resident's room and fixed the resident's tube feeding. The LPN did not wear a gown when he/she assisted the resident with the his/her tube feeding. Observation on 09/10/24 at 10:16 A.M., showed Certified Nurse Aide (CNA) E entered the resident's room. The CNA assisted the resident out of bed and did not wear a gown. Observation on 09/12/24 at 7:54 A.M., showed LPN M administered the resident's medications through his/her feeding tube. LPN M did not wear a gown when he/she administered the resident's medications. Observation on 09/12/24 at 8:18 A.M., showed CNA I showered and transferred the resident. The CNA did not have a gown on. Observation showed Registered Nurse (RN) H started the resident's tube feeding and did not have a gown on. The resident's room did not have an EBP sign on the door. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265581	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingdom Care Senior Living LLC	811 Center Street Fulton, MO 65251

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #28's Discharge Assessment MDS, dated [DATE], showed staff assessed the resident admitted to the facility on [DATE] and required a feeding tube. Review of the resident's POS, dated September 2024, showed an order for enteral feeding, continuously of Jevity 1.2 Calories. Observation on 09/09/24 at 10:55 A.M. showed the resident received his/her tube feeding in his/her room. Observation showed outside the resident room did not contain an EBP sign posted outside the resident's room or PPE station observed inside or outside the resident's room. Observation on 09/10/24 at 8:53 A.M. showed the resident received his/her tube feeding in his/her room. There is no EBP sign posted outside the resident's room or PPE station observed inside or outside the resident's room. Observation on 09/12/24 at 8:21 A.M., showed Certified Medication Technician (CMT) J entered the resident's room and assisted the resident with perineal care. The CMT did not wear a gown when he/she provided care to the resident. 4. During an interview on 09/12/24 at 10:03 A.M., CNA I said he/she does not remember receiving training on EBP and had not used a gown when caring for residents with a catheter or feeding tube. During an interview on 09/12/24 at 10:07 A.M., RN H said he/she does not know what EBP is. The RN said he/she does not think there is any residents on EBP. The RN said he/she would not know what residents should be on EBP, because he/she doesn't even know what the definition of EBP is. The RN said he/she does not wear a gown when providing care for resident #9 and #28. The RN said the two resident's do not have gowns or signs for EBP outside their rooms. The RN said the aides do not wear gowns when providing the two resident's care. During an interview on 09/12/24 at 10:08 A.M., CMT J said he/she guessed he/she did not receive education for EBP use. The CMT said he/she did not know EBP should be used during care for residents with feeding tubes and catheters. During an interview on 09/12/24 at 10:25 A.M., CNA E said he/she used gloves when providing care for residents with feeding tubes, but he/she does not wear a gown. The CNA said he/she does not know what EBP are. The CNA said he/she hasn't seen any signs posted. During an interview on 09/12/24 at 10:25 A.M., the Director of Nursing (DON) said he/she is not familiar with EBP and the facility is not following it. The DON said it could be an infection control concern if staff is transferring germs from resident to resident. During an interview on 09/12/24 at 10:29 A.M. the administrator said he/she is not familiar with EBP, and the facility does not have any residents on EBP. The administrator said he/she currently does not have any EBP signs posted outside any resident doors. The administrator said he/she does not know why EBP signage is not posted outside the resident doors. The administrator said he/she can not say why staff are not wearing gowns, honestly. The administrator said it is his/her and the DON's responsibility to ensure staff are are wearing gowns with residents on EBP, we did not set equipment out for the staff to use. (continued on next page)

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	265581	A. Building B. Wing	09/12/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/12/24 at 1:19 P.M., the Administrator said the Infection Preventionist is responsible for updating staff training when new requirements come out to be used. The administrator said they were aware of EBP for multi drug resistant organisms, but did not know it also applied to feeding tubes or catheters, intravenous access devices, and wounds. 45489