STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265823	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Health Care Center, LLC	11400 Mehl Avenue Florissant, MO 63033

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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** Based on observation and interview, the facility failed to follow its cleaning policy when staff did not provide residents with a clean, sanitary, and homelike environment. Facility staff failed to thoroughly clean two residents' rooms (Resident #30 and Resident #29). The facility also failed to use proper precautions when handling soiled towels and/or linen, affecting all residents residing at the facility. In addition, the facility also failed to thoroughly clean shower rooms on the 100 and 200 halls after resident use. This had the potential to affect all residents who utilized those shower rooms. The sample was 32. The census was 139. Review of the facility's Housekeeping Deep Cleaning policy, revised 6/29/23, showed: -Purpose: To ensure all rooms are clean; -Policy: Deep cleaning is to be completed as scheduled. This includes complete pull-outs of furniture in rooms, wall cleaning, floor cleaning (scrubbing and waxing included), restrooms to be cleaned and disinfected, cob webs removed, beds and rails to be cleaned, sprinkler heads to be cleaned, light covers to be clean and free of bugs, over-bed light covers to be cleaned and free of bugs, sink clean, windows to be cleaned and ensure no spider webs, drapes and curtains to be cleaned (including privacy curtains), call lights to be clean and free form dust/dirt build-up, floors and closets and doorways are to be free from wax/dirt build-up, etc; -All areas should be monitored on a daily basis and all resident living areas and non-living areas should be clean and odor free; -Daily Cleaning: -Pick up all trash and put into trash can and empty; -Dust mop or sweep floor; -Submerge rag or sponge in with solution and clean surfaces beginning with touch areas on door and work clock or counterclockwise around the room; -Surfaces are to be cleaned including wall smudges, light and call light and side tables, head/foot board/side rails of beds, windows; (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Clean the sink around the light fixtures and dispensers; -Clean inside and outside of the trash can. Let it air dry. Replace trash can liner; -Clean bathroom using the same cleanser/disinfectant wall smudges, lights, and call switches and support rails. Use honey bowl to clean inside, outside toilet tank, seat and bowl; -Clean shower rooms inside the shower, around the shower, and the base boards in the rooms; -Resident Room Deep Clean: All resident rooms will be deep cleaned once monthly or more often if needed. As in the case of heavy care rooms; -All above-floor bathroom surfaces will be cleaned with a cleaner/disinfectant; -Bathroom floors will be swept and mopped and any dirt, grime or stains will be hand scrubbed with stiff brush or other equipment suitable for removing surface dirt from entire floor. If the stain in not removeable then housekeeper will notify maintenance department with maintenance form request form; -All furniture will be removed, cleaned behind, and upholstered furniture will be thoroughly cleaned; -Resident bed will be stripped with both frame and mattress cleaned with disinfectant cleaner; -Glass surfaces will be cleaned; -Necessary wall washing to remove smudges and spots will be done with disinfectant cleaner. Review of the facility's Safe and Homelike Environment Policy, revised 6/5/24, showed: -Purpose: In accordance with resident's rights, the facility will provide a safe, clean, comfortable and home like environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk; -Definitions: -Environment: refers to any environment in the facility that is frequented by residents, including (but not limited to) the resident's room, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas; -Homelike environment: A determination of homelike should include the resident's opinion of the living environment; -Sanitary: includes, but is not limited to, preventing the spread of disease-causing organisms, by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in the completion of the activities of daily living; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Policy: Housekeeping and Maintenance services will be provided as necessary to maintain a sanitary and comfortable environment; -General Considerations: -Minimize odors by disposing of soiled linens promptly and reporting lingering odors and bathrooms needing cleaning to housekeeping department; -Report any furniture in disrepair to maintenance promptly; -Report any unresolved environmental concerns to the Administrator. Review of the facility's Environmental Room Attendants Checklist, copyright 2023, showed: -Instructions: Use this checklist to perform compliance rounds for environmental room attendants on a regular basis. For Quality Assurance (QA) purposes only: -Bedrooms: -Walls; -Trash can; -Furniture; -Floors/Corners/Jambs; -Window sill/ledge/blinds; -Window; -Bed frames/rails; -Cubicle curtain; -Over the bed tables; -High/low dusting; -Lights; -Light switches: -Mirror/pictures; -Vents/heaters; ` (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Door knobs/handles; -Call bells; -Closet floors; -Bathrooms/Showers: -Paper towel dispense; -Hand soap dispenser; -Sink/faucet; -Toilet; -Vents; -Lights; -Light switches; -High/low dusting; -Mirror/cabinet; -Trash can; -Baseboard: -Ledges; -Floor; -Door knobs/handles; -Toilet paper (TP) dispenser. Review of the facility's Floor Techs duties, no date, showed: -Removing trash; -Running cleaning machine; -Buffing floors; -Cleaning dining room (sweeping, tables, chairs, and mopping). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Handling Clean and Dirty Linen Policy, revised 6/26/24, showed: -Purpose: It is the policy of this facility to handle, store, process, and transport clean and soiled linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection; -Definitions: -Hygienically clean means rendered free of vegetative pathogens through disinfection during laundering process; -Linen includes sheets, blankets, pillows, towels, washcloths, and similar items from departments such as nursing, dietary, rehabilitative services, beauty shops, and environment services; -Contaminated linen is linen that has been soiled with blood or other potentially infectious materials; -Policy: Clean Linen: Linen can become contaminated with pathogens from contact with intact skin or body substances, or from environmental contaminants or contaminated hands; -Clean linens must be transported by methods that ensure cleanliness and protect from dust and soil during intra or inter-facility loading, transport and unloading, such as: -Wrapping the individual bundles of clean textiles in plastic or other suitable material and sealing or taping the bundles; -Guidelines for the storage of clean linen include, but are not limited to, the following: -Do not place clean linen on the floor or other contaminated surfaces. Limit linen in the resident's room for immediate use only (do not store up linen in resident rooms to prevent inadvertent contamination); -Soiled Linen: -Linen can become contaminated with pathogens from contact with intact skin, body substances, or from environmental contaminants. Transmission of pathogens can occur through direct contact with linens or aerosols generated from sorting and handling contaminated linens; -All used linen should be handled using standard precautions (i.e., gloves) and treated as potentially contaminated. Other protective equipment may be required. Examples of linen that may require special handling include, but are not limited to: -Visibly soiled with blood or large amounts of body fluids; -Residents with infectious drainage not contained by dressings or other supplies; -Residents with infections transmitted by contact; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Linen should not be allowed to touch the uniform or floor and should be handled as little as possible, with minimum agitation to avoid contamination of air, surfaces, and persons; -Used or soiled linen shall be collected at the bedside (or point of use) and placed in a linen bag or designated lined receptacle. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Soiled linen shall not be kept in the resident's room; -If linen is heavily soiled, wet, and/or presents a risk of leakage or soaking through, the linen shall be double bagged. Double bagging is also recommended when the outside of the bag is visibly soiled or wet; -Storing and rinsing of contaminated linens at the point of use, hallways, or other open resident care spaces is prohibited; -Wash hands after contact with soiled linen. 1. Review of Resident #30's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/5/25, showed: -Cognitively intact; -Lower extremity impairment on both sides; -Electric wheelchair; -Diagnoses include paraplegia (a condition characterized by the paralysis of the lower half of the body, including the legs and sometimes the trunk and pelvic organs), depression and anxiety disorder. During an interview on 6/13/25 at 11:20 A.M., the resident said his/her room was filthy and the floor was dirty. The resident said he/she couldn't remember the last time housekeeping had cleaned his/her floor. He/She said the aides had stopped helping him/her in his/her room. He/She needed help hanging up the piles of clothes on his/her bedside table and keeping his/her room clean. He/She was paralyzed from the waist down. He/She didn't know why the aides weren't helping him/her. No one at the facility was proactive and the facility got rid of the good workers. He/She used the showers, but the showers remained nasty. He/She didn't want to use the showers because he/she wouldn't feel clean. The facility was not sanitized. Housekeeping staff were not doing their jobs. He/She wouldn't lie on them. Observation on 6/13/25 at 11:20 A.M., showed heavy thick, dark colored build-up of dirt at the entrance to and inside of the resident's room. The door scraped through the dirt build-up in certain spots. The dirt build-up looked patchy and sticky. There was a mound of clothing on top of the resident's bedside tray table and on the roommate's side of the room. Bags of opened clean briefs were on the floor. The resident's trash can didn't have a plastic liner inside of it. There were two soiled briefs inside of the trash can, one of which was hanging outside of the trash can. There was a small cardboard rectangular box, blue rubber gloves, and other trash inside of the unlined trash can. There was another box on the floor with trash inside of it. Certified Nurse Aide (CNA) D picked up the trash can, walked it outside of the resident's room and emptied it into his/her housekeeping cart. (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 6/13/25 at 11:45 A.M., CNA D said the resident's trash can should have had a plastic liner inside of the trash can before trash had been put inside of it. 2. Review of Resident #29's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -Wheelchair; -Manic depression (bipolar disorder, a mental health condition characterized by extreme mood swings). Observation of the resident's room on 6/12/25 at 1:22 P.M., showed a sticky floor, with built-up dirt. There was trash, a waded up white sheet and broken broom head on the floor at the foot of the resident's bed. There was a dried pile of old white beans on one of the legs of the resident's bedside tray table. Observation on 6/13/25 at 11:05 A.M., showed the floor in the resident's room made a sticky sound when it was walked on. The floor had built-up dirt, debris, and the room trash can was overflowing. The pile of dried white beans was still in the foot of the bedside tray table. During an interview on 6/13/25 at 11:05 A.M., the resident said his/her floor had been mopped that morning. He/She didn't know the floor was sticky because he/she was in a wheelchair. He/She said his/her room could be cleaner. The showers were usually not clean. Towels were left on the floor in the 200 hall shower room. He/She said the showers used to be nastier than what they are right now. He/She had seen the black stuff in the shower. He/She said it might be mold but didn't want to say that because he/she was not sure. It bothered him/her that the shower was nasty but he/she didn't know who was supposed to clean it. During an interview on 6/13/25 at 10:45 A.M., Housekeeper I said he/she was assigned to the resident's room yesterday and he/she didn't know why his/her room was dirty. Observation of the resident's bedside tray table on 6/13/25 at 11:55 A.M., showed dried white beans and black soot build up on the foot of the bedside table. During an interview on 6/13/25 at 11:55 A.M., CNA J said he/she the resident's room was not clean, and the dried beans and black soot should not be there. He/She looked surprised when he/she saw the dried beans and black soot. If this was his/her house, he/she would clean this. His/Her house wouldn't look like this. During an interview on 6/12/25 at 1:22 P.M., the Housekeeping Supervisor said she didn't know how long the broken broom head had been on the floor or how it got into the resident's room. She said housekeeping was supposed to clean resident rooms, but they didn't move or touch resident's personal belonging or linen. They cleaned around the room. Sometimes residents didn't want to leave the room for it to be cleaned/stripped/waxed. She said the resident's room had been cleaned and his/her floor had been stripped a couple of weeks ago. (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 6/13/25 at 9:45 A.M., the Housekeeping Supervisor said after each shower, the aides were supposed to clean up and put any wet towels in the large barrel located inside of the shower room. The Housekeepers did not handle any linen left inside the shower rooms. They only sanitized the showers afterwards. During an interview on 6/13/25 at 10:45 A.M., Housekeeper I said the floors were swept and mopped every day. He/She didn't see feces on the floor yesterday or today. 100 hall shower was for the residents who were on that hall. The shower was a community shower. It should be cleaned daily. No wet or soiled towels/linen should be on the bathroom floor. When the residents came to take a shower, the aides/nurse assigned to the resident was supposed to pick up the wet/soiled towels and/or linen and put into the barrels. Resident rooms were cleaned daily. During an interview on 6/13/25 at 10:53 A.M., CNA B said the aides were supposed to get the wet towels/linen out of the shower room after the resident was finished in the shower room. The aides were supposed to gather all the supplies before the resident went into the shower room. No linen or wet towels were supposed to be left on the floor. Linen was not supposed to be on the floor anytime without being inside of a plastic bag. The bag should be tied, and the dirty linen taken to the soiled utility room. He/She went into the resident rooms and said the rooms were clean. She said the floors were clean. CNA B had not seen any feces on the floor but said feces on the floor was not considered sanitary or clean. If he/she saw feces on the floor at his/her house, he/she would clean it up right away. 6. Observation of the 200 Hall shower room on 6/13/25 at 10:56 A.M., showed one wet towel on the sink. Hair and black soot and debris build-up were visible on the inside of the shower all the way around the creases, on the outside of and in front of the shower. During an interview on 6/12/25 at 10:55 A.M., Resident #32 said he/she didn't want to take a shower in the shower room. He/She thought he/she was dirtier after using the shower in there. He/She said staff didn't clean the shower up after other residents took a shower. During an interview on 6/12/25 at 10:55 A.M., Resident #11 said the floors in the shower were dirty and hair was on the floor. The shower was disgusting. He/She said the shower was nasty and it made him/her not to want to get cleaned up. 7. During an interview on 6/13/25 at 1:35 P.M. and 1:45 P.M., the Housekeeping Supervisor said she didn't have a checklist to tell staff what to clean in rooms from day to day or for deep cleaning. There was not a schedule for the floor techs either, but she was going to get a schedule together. The Housekeeping Supervisor said she was over the floor techs. The facility had just gotten two Floor Techs that knew what they were doing. Resident rooms were hit and miss for cleaning. She didn't have a schedule of assigned tasks for the Housekeeping staff to complete in resident rooms on a daily, weekly, or monthly basis. They tried to clean resident rooms on the weekends. They cleaned 600 hall about two weeks ago. Some residents didn't want to leave their room for housekeeping to clean the rooms and floors. She said she should have had a schedule of tasks assigned to the Housekeeping Aides. She expected there to be a schedule so Housekeeping staff knew how to clean and how often to clean resident rooms, shower rooms, and other assigned areas in the facility. She said there would be a schedule made. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to follow their Abuse and Neglect policy when they failed to notify the Department of Health and Senior Services (DHSS) after Certified Medication Technician (CMT) F threw Kool-Aid in Resident #25's face on the morning of 5/28/25. The census was 139. Review of the facility Abuse and Neglect Policy revise on 6/12/25, showed: -Purpose: It is the policy of this facility to report all allegations of abuse/neglect/mistreatment immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames; -Definitions: -Mental Abuse: Mental abuse includes, but is not limited to humiliation, harassment, threats of punishment or deprivation. Mental abuse includes the use of verbal or nonverbal conduct witch causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation; -Mistreatment: Mistreatment is inappropriate treatment or exploitation of a resident; -Notifications: Report to State, Law Enforcement , and Others: -Refer to the State Operations Manual for reporting and utilize the Abuse-Neglect Reporting Decision Tree to assess the particular incident. Should the incident be a reportable event, notify the appropriate agencies immediately: as soon as possible, but no later than 24 hours after discovery of the incident. Review of Resident #25's admission Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 4/9/25, showed: -Makes Self Understood: Understood; -Ability To Understand Others: Understands; -Speech Clarity: Clear speech, distinct intelligible words; -Cognitively intact; -Diagnoses of depression and manic depression (bipolar disease a mental disorder characterized by periods of depression and periods of abnormally elevated mood). (continued on next page)

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	265823	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestwood Health Care Center, LLC	11400 Mehl Avenue Florissant, MO 63033

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/25 at 11:55 A.M., the resident said a couple of weeks ago he/she called CMT F a bitch, which he/she should not have done. CMT F threw Kool-Aid in his/her face. That pissed him/her off and he/she began kicking the hall doors. The Administrator and other staff came to the doors to find out what was going on. He/She told the Administrator what happened. The Administrator sent CMT F home and he/she had not seen the CMT since then. Review of the facility's Investigation dated 5/29/25 at 9:52 A.M., completed by the Director of Nursing (DON), showed: -Date of incident: 5/28/25; -Type of Incident: Allege abuse; -Persons involved in the alleged incident: CMT F and Resident #25; -Date and Time notified: 5/28/25 at 9:30 A.M.; -Investigative Narrative: At approximately 9:30 A.M. on 5/28/25 per resident, the resident was at the CMT cart and upset. Per resident, he/she called CMT F a bitch and the CMT threw Kool-Aid in the resident's face; -CMT F was terminated on 5/29/25; -Criteria for Self Reporting: Was this a result of abuse: Yes (Yes = Report). During an interview on 6/13/25 at 1:35 P.M., the DON said she was off from 5/21/25 through 5/27/25. When she returned around noon on 5/28/25, she was told what happened. She was asked to begin the investigation at that time. She assumed since the incident occurred prior to her coming in that day DHSS had already been notified. During an interview on 6/13/25 at 2:02 P.M., the Administrator said he heard the resident kicking the doors that day. He immediately responded. The resident told him what happened. The CMT gave a statement and was sent home. When the DON came in later that day, she was told what happened and he asked the DON to investigate the incident and he assumed she would notify DHSS. DHSS should have been notified per the facility policy. MO00255781

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure one resident with a history of elopement was provided with adequate supervision and staff oversight. On 5/14/25, Resident #16 was left unsupervised in the courtyard during a smoking break. The resident used a chair in the courtyard to climb over the fence and was noticed in the road close to the facility by an off duty staff member. On 5/24/25, the resident once again used a chair in the courtyard to climb over the fence. The resident was not noticed missing for three to four hours and was found approximately 3.7 to 4.7 miles from the facility, depending on the route the resident walked. In addition, the Administrator confirmed that one of the two exit doors in the dining room had an alarm that was faint for approximately one month before 6/8/25 when Resident #18 left the facility through the door and was noticed by a staff member in the parking lot. The facility identified 45 residents as a high risk to elope and problems were found with two. The census was 139. Review of the facility Elopements And Wandering Residents policy last reviewed on 6/12/24, showed: -Purpose: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk; -Definitions: Elopement: Elopement occurs when a resident leaves the premises or a safe area without authorization and/or necessary supervision to do so; -Policy:Preventing Elopements: 1. The facility is equipped with door locks/alarms to help avoid elopements; 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner; 3. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary; 4. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering: 1. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team; 2. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-7/10/24: Problem: At risk for the following signs/symptoms related to diagnoses of schizophrenia, aggression, and anxiety. Goal: Will have decreased signs and symptoms. Interventions: Avoid arguing or getting defensive with resident. Notify charge nurse if you notice hallucinations, delusions, irritability, talks to self, anxiety or aggression; -9/16/24: Problem: This is resident's safety plan. Goal: Resident's personal goal is: Want to leave. Interventions: The following worked well in the past: listening to jazz music. These are the steps resident wants to make his/her environment safer: be left alone. Review of the resident's Elopement Evaluation, located in the EMR, dated 4/27/25 at 9:58 A.M., showed: -Does the resident have a history of elopement or an attempted elopement while at home: Yes; -Does the resident have a history of elopement or attempted leaving the facility without informing staff: Yes; -Has the resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door: Blank; -Does the resident wander: No; -Score value of 1 or higher indicates Risk of Elopement. Review of the resident's progress note dated 5/14/25 at 4:38 P.M., and documented by Licensed Practical Nurse (LPN) A, showed: Resident was outside smoking with staff and other residents. The resident then walked out of the gate. Staff retrieved resident and brought back into the facility. Resident agitated, yelling, and cursing staff due to resident being brought back in the facility. Resident was assisted to the locked hall due to agitated and combative behavior. Call placed to resident's physician to inform of behavior. Review of the facility Admin/RN (Registered Nurse) Investigation located in the EMR, completed by the DON and dated 5/14/25, showed: -Date of Incident: 5/14/25; -Type of Incident: Elopement; -Witnesses: None; -Statements received from witnesses: NA (not applicable); -Documentation of incident completed: Yes; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Investigation Narrative Note: Resident noted by a staff member who was driving by the facility that the resident was walking in the street. Resident was retrieved and brought back to the building. Resident refused to make a statement due to being agitated. Spoke with resident on 5/15/25, and he/she will not respond to the writer. Certified Nurse Aide (CNA) C remembered seeing the resident out back before taking his/her resident in from smoking. Stated that no one was left outside smoking. CNA O stated he/she went inside when the residents were smoking and did not see anything. CNA Y stated that CNA S said the resident must of got out when he/she came back in the building. CNA Z stated he/she went with staff to get the resident. They saw the resident walking and got him/her into the car; -Care Plan changes and interventions: Staff to ensure resident re-enters building after smoking. Staff to keep resident away from fence during smoking. Staff was inserviced on elopement and supervised smoking. During an interview on 6/11/25 at 10:43 A.M., CNA O said he/she worked the evening shift (3:00 P.M.-11:00 P.M.) on 5/14/25. The resident was independent for his/her activities of daily living and spent a lot of his/her time in the dining room. He/She had never seen the resident trying to leave the facility before. At some point during the shift someone brought the resident back to the facility. He/She had just seen the resident in the facility about 30 minutes prior to being brought back. CNA O did not even know the resident was missing before being brought back. He/She did not hear any door alarms sounding. The resident was moved to the locked hall after being brought back. During an interview on 6/12/25 at 10:54 A.M., the DON said she completed the elopement investigation for 5/14/25. On that day she had just left for the day when the Administrator called her and said the resident had eloped from the building and was found by staff about a block away from the facility. She asked the Staffing Coordinator to initiate the investigation by getting staff statements. They think the resident did not come back in the facility after smoking and left through an unlocked gate. She had not received any statements indicating the resident had used a chair to climb over the fence. Nursing staff were inserviced on the facility elopement policy and supervised smoking on 5/14/25. During an interview on 6/12/25 at 1:58 P.M., the Administrator said he spoke to the resident regarding the elopement on 5/14/25. The resident told the Administrator he/she had pulled a chair to the fence in the courtyard and used it to climb over the fence. The resident demonstrated to the Administrator what he/she had done. The Administrator was not sure if he told the DON about the resident saying he/she had used a chair to climb over the fence. Review of the resident's care plan, showed:5/14/25: Problem: Resident exited courtyard after smoking. Goal: Resident will stay in the facility courtyard during smoke breaks and go back in the building after smoke breaks. Interventions: Staff to ensure resident reenters building after smoking. Staff to keep resident away from fence during smoke breaks. Review of the resident's Monthly Nurses Note, dated 5/18/25 at 9:24 A.M., showed: -Hearing: Good; -Speech: Clear; -Makes self understood: Understood; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Vision: adequate; -Indicators of Delirium: Disorganized thinking; -Memory: Short/long term memory problem; -Daily Decision Making Skills: Modified independence, some difficulty in new situations; -Behavior Symptoms: Rejects care; -Transfer: Independent; -Mobility Devices: None; -Activities of Daily Living Self Performance Definitions: Supervision, oversight, encouragement or cueing. Review of the resident's progress notes, showed: -5/22/25 at 3:15 P.M., and documented by RN B: While going on break noted alarm going off for the court yard on 100 hall. Noted resident sitting outside by himself/herself in courtyard. When resident asked how he/she got outside he/she said that he/she pushed the door open. Re-directed resident back inside and Assistant Director of Nursing (ADON) and nurse made aware; -5/24/25 at 9:15 A.M., and documented by RN C: Resident noted to not be in the building at A.M. med pass. Code [NAME] called. Resident noted to have pushed his/her way out 100 hall door, put chair up to fence and climbed the fence. Resident caught in the parking lot. Returned to facility and placed on the locked hall with one on one. During an interview on 6/12/25 at 7:22 A.M., LPN E said he/she worked the night shift (beginning at 11:00 P. M. on 5/23/25 and ending at 7:00 A.M. on 5/24/25). CNAs were suppose to do face checks on all residents every hour and do rounds on residents every two hours. LPN E did rounds on all of his/her halls when he/she first reported to work. He/She would not check residents routinely unless they had a medication or a reason to assess them more frequently. At the end of the shift no one told LPN E anything about not being able to find the resident. He/She did not hear any door alarms sounding. If a resident was suspected to be missing LPN E would call a Code White. If the resident could not be found inside or outside the facility then he/she would call the police, DON and Administrator. LPN E would not wait to call the police until staff were finished searching in cars. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 12:14 P.M., CNA Q said he/she came to work on 5/24/25 at 7:00 A.M. He/She was assigned to the resident that day. The resident needed some oversight for activities of daily living. The resident could walk independently, but walked at a slow pace. Prior to 5/24/25, CNA Q had never seen the resident leave the facility without supervision. He/She had seen the resident pushing on exit doors before. When CNA Q got to the facility that day he/she began his/her rounds. He/She did not see the resident during rounds, but thought the resident may have already been in the dining room. CNA Q was going to go and check the dining room, but another staff member asked him/her to help with another resident. After that he/she forgot to check the dining room for the resident. He/She did not hear any door alarms sounding that day. Sometime around 9:00 A.M., a Code [NAME] was called and they said they could not find the resident. They searched in and around the facility and could not find the resident. A short time later staff had brought the resident back to the facility. He/She was inserviced on elopements after that occurred. During an interview on 6/11/25 at 3:03 P.M., RN C said Certified Medication Technician (CMT) M notified him/her around 9:00 A.M., the resident could not be found. No door alarms had sounded. He/She called a Code [NAME] at that time. They completed a search for the resident inside and outside the facility and could not find the resident. RN C did not call the police after it was determined the resident was missing. He/She would have called the police if the resident had not been found by staff searching in cars. He/She knew the resident was not found in the parking lot, but documented that because the former ADON had told him/her to. When the resident returned to the facility, he/she said it was dark outside when he/she had left. The resident was not injured. During an interview on 6/11/25 at 1:45 P.M., the Maintenance Director confirmed he was in the car when they found the resident near Riverside Circle. He and two other staff were in the car and returned the resident to the facility. The resident was found approximately 35 to 45 minutes after the Code [NAME] was called. During an interview on 6/12/25 at 8:15 A.M., CNA N said he/she was working on the day shift of 5/24/25. He/She did not hear any door alarms sounding prior to the Code [NAME] being called. He/She was with the Maintenance Director when they found the resident at St. [NAME] road and Route 367. Review of Google maps showed the resident was approximately 3.7 miles to 4.7 miles from the facility when found by staff, depending on the route the resident walked. During an interview on 6/12/25 at 6:38 A.M., LPN W said staff should check on residents at least every two hors. If a resident was not accounted for then a Code [NAME] should be called and all staff should search both inside and outside the facility. If the resident is not located, the police should be notified immediately. Review of the resident's Elopement Evaluation dated 5/24/25 at 1:31 P.M., showed: -Does the resident have a history of elopement or an attempted elopement while at home: No; -Does the resident have a history of elopement or attempted leaving the facility without informing staff: No; -Has the resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door: No; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Does the resident wander: Yes; -Is the resident's wandering behavior likely to affect the safety or well-being of self/others: No; -Score value of 1 or higher indicates Risk of Elopement. Review of the resident's care plan, showed: 5/24/25: Resident attempted and was able to get out of facility. Goal: Resident will not be able to leave the building without the awareness of staff through next review. Interventions: Resident was placed on one on one for 72 hours for protective oversight. Resident is placed on every 15 minute rounding/face checks post one on one. Psychiatrist to review medications. Resident will meet with the interdisciplinary team to discuss what the university is. Review of the facility Admin/RN Investigation report dated 5/30/25 at 11:04 A.M., and completed by the DON, showed: -Date of incident: 5/24/25; -Type of incident: Elopement; -Witnesses: None; -Investigative Narrative Note: Resident noted not to be in the building during A.M. med pass. Code [NAME] was called. Resident noted to have pushed his/her way out 100 hall door, put chair up to fence and climbed the fence. CM M stated on the morning shift of 5/24/25 at 7:00 A.M., he/she was doing her rounds. He/She walked 400 hall and then 100 hall. He/She did not see the resident and then proceeded to check 600 hall. He/She checked 600 hall and did not find the resident around 9:15 A.M. The Maintenance Director stated he found the resident at Riverview Circle. The Maintenance Director was in the car with two other staff. The resident said he/she left the facility around 5:00 A.M. Resident stated he/she went to the door to the courtyard and pushed until it opened. He/She then said he/she pulled a chair to the gate and climbed up and over the gate. Resident stated he/she then started walking to go home and wanted to visit the university. Maintenance Director stated he found the resident at Riverview Circle. He was in the car with two other staff. CNA N was in the car and stated they found the resident walking on route 367; -Care Plan changes and interventions: Resident moved to 600 hall and placed in a room that window faces the courtyard. Resident was placed one to one. Psych to review med's. Fence around 600 hall courtyard has a smooth surface with no place to put feet to climb over. Activities will invite resident to groups. During an interview on 6/11/25 at 10:00 A.M., CMT M said he/she worked the day shift (7:00 A.M. - 3:00 P.M.) on 5/24/25. He/She did not hear any of the door alarms sounding that day. He/She started his/her medication pass and could not find the resident. CMT M told RN C that he/she could not find the resident around 9:00 A.M. or 9:15 A.M. The RN called a Code White. They searched inside and outside and could not find the resident. CMT M was inserviced on elopements after that occurred. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 10:25 A.M., CNA D said he/she worked on the 500 hall on 5/24/25. He/She started around 7:00 A.M. CNA D did not hear any door alarms sounding that day and had no idea how the resident exited the building. Around 9:00 A.M., there was a Code [NAME] called and they all started to search the facility and grounds. About 35 to 45 minutes later, staff brought the resident back to the facility. They were inserviced on elopement after that occurred. During an interview on 6/12/25 at 10:54 A.M., the DON said she was gone from the facility from 5/22/25 through 5/27/25, and returned on 5/28/25. The former ADON was in charge of the resident's elopement investigation on 5/24/25. She had no knowledge of the elopement until she returned. After returning she reviewed the ADON's investigation. There were no interviews with the three staff that found the resident. She began another investigation and started elopement inservicing with all staff. That inservicing was completed on 5/30/25. She did not know how the resident got out of the facility without a door alarm sounding. Staff ideally should check on residents at risk to wander or elope every hour, but no longer than every two hours. She would have expected RN C to have followed the facility policy and contacted the police when the resident could not be located in the facility or on the facility grounds. Review of the Psychiatric Nurse Practitioner (NP) Visit - Mental Status Exam located in the EMR, and completed on 5/29/25, showed: -Reason for Visit: Follow-up elopement attempt; -History of Present Illness: Resident attempted to elope from the facility. He/She was successfully redirected back to the facility without any issues. Attended interdisciplinary team meeting and discussed with nursing staff on safety plan to decrease risk for future elopement attempts and necessitates increased monitoring and safety measures. Continue monitoring resident's behavior and compliance with facility rules; -Review Summary of Old Records: Recently moved to 600 hall for increased supervision following elopement attempt; -History from Nursing: On May 24, resident attempted to leave the facility by pushing through a door, using a chair to climb a fence, and was subsequently found in the parking lot. During a telephone interview on 6/12/25 at 1:23 P.M., the Psychiatric NP said she was asked to review the resident's medications because the resident had eloped from the facility and was found on the parking lot. She was not told the resident had been found 3.7 to 4.7 miles from the facility. She should have been told that because it would make a difference regarding safety issues. She had not been told the resident eloped on 5/14/25 either. It was not safe for the resident to be outside the facility without supervision due to his/her diagnoses of schizophrenia and dementia. She did not feel the resident was cognitively able to make decisions for himself/herself. She felt the resident should not be his/her own responsible party and the facility should explore a legal guardianship for the resident. She discussed that with the DON the last time she was at the facility. During an interview on 6/12/25 at 1:37 P.M., the DON said she agreed with the Psychiatric NP, the resident is not safe to be wandering around the community unsupervised, and also agreed it was time to discuss obtaining a legal guardian with social services and the resident's physician. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/25 at 1:58 P.M., the Administrator said he was home on 5/24/25. Around 10:00 A. M., staff called him and informed him the resident was missing from the facility and the facility grounds. While he was getting ready, the staff had called him back and said the resident was found unharmed and was back at the facility. He was told by the former ADON the resident was found on the parking lot. It was not until the next day he learned the resident was found a few miles away. Per facility policy, RN C or the ADON should have called the police when the resident was not found on site. The ADON was responsible to initiate the investigation and the DON completed the investigation upon her return on 5/28/25. All staff were inserviced on the elopement policy on 5/29/25. During an interview on 6/11/25 at 8:38 A.M., the resident was fully dressed and lay on his/her back on the bed with his/her eyes closed. He/She was awake. The resident said the first time he/she left the facility he/she was less than a mile from the facility when staff found him/her and brought the resident back to the facility. The second time he/she was more than a mile or two away from the facility. Both times he/she used a chair to climb over the fence. The resident did not answer when asked if he/she was going to leave the facility again. Review of the resident's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Sit to stand: Supervision or touching assistance - Helper provides verbal cues or touching/steadying assistance as resident completes activity; -Walk 10 ft: Supervision or touching assistance; -Walk 50 ft: Supervision or touching assistance; -Walk 150 ft: Supervision or touching assistance. 2. Review of Resident #18's quarterly MDS dated [DATE], showed: -Adequate hearing and vision; -Speech Clarity: Clear speech, distinct intelligible words; -Makes Self Understood: Understood; -Ability to Understand Others: Understands; -Cognitively intact; -No behavioral issues; -Wandering: Behavior not exhibited; -Independent: Sit to stand, walk 10 ft, walk 50 ft and walk 150 ft; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses of seizure disorder, anxiety, depression and manic depression (bipolar disorder/a mental disorder characterized by periods of depression and periods of abnormally elevated mood). Review of the resident's care plan, showed: -6/7/21: Problem: History of behavioral challenges that require protective oversight in a secure setting including attempts to elope. Goal: Resident will have no serious injuries due to behaviors. Interventions: CALM technique (de-escalation method) if needed. One on one interventions as needed; -6/7/21: Problem: Independent with activities of daily living. Goal: Will have no decline in activity of daily living performances. Interventions: Provide protective oversight and assist where needed; -6/7/21: Problem: Resident displays impaired cognitive function/dementia or impaired thought processes. Goal: Resident will maintain current level -9/17/24: Problem: Safety plan. Goal: Personal goal is baseball. Interventions: Warning signs are:passing out. Review medications with resident to ensure resident understands what medications he/she is taking. These are the items resident wants to work on: Getting out of here; -2/21/25: Problem: Resident's emotional distress is triggered by overwhelming emotions or feelings or memories. Goal: Decrease the amount of triggers happening and minimize negative outcomes related to triggers. Interventions: Practice self-care. Practice sensory interaction in a moment of crisis to ground self to the present. Review of the resident's Elopement Evaluation, dated 5/30/25 at 2:02 P.M., showed: -Does the resident have a history of elopement or an attempted elopement while at home: No; -Does the resident have a history of elopement or attempted leaving the facility without informing staff: No; -Has the resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door: No. Review of the resident's care plan, showed: -6/8/25: Problem: Resident exited building trying to go home. Goal: Resident will not elope. Interventions: Resident placed on 600 hall with every 15 minute checks for 72 hours. Educated the to tell the nurses when he/she wants to go home and not leave the building. Review of the resident's Elopement Evaluation, dated 6/9/25 at 8:34 A.M., showed: -Does the resident have a history of elopement or an attempted elopement while at home: Yes; -Does the resident have a history of elopement or attempted leaving the facility without informing staff: Yes; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Has the resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door: No; -Score value of 1 or higher indicates Risk of Elopement. Review of the resident's progress note, dated 6/8/25 at 10:20 P.M., and documented by LPN A, showed at approximately 8:10 P.M., CNA informed this nurse that this resident had gotten out of the building. Code [NAME] was called and description of resident wearing gray/black plaid sleep pants with gray short sleeve shirt was given and staff headed to car to go and look for resident. At approximately 8:15 A.M., staff member who was on break at the time saw this resident running towards the apartments (next to the facility). Staff member was able to get the resident into his/her car and brought resident back to facility. Resident was calm and apologetic at this time. Resident stated he/she was angry because he/she was in this facility and did not want to be here. He/She pushed the door in the dining room open and ran towards the apartments where a staff member saw him/her and asked him/her to get into the car and brought him/her back to the facility. No acute distress noted. Physician and Psychiatrist notified. Resident placed on locked hall for more intense monitoring and every 15 minute checks were initiated. During an interview on 6/11/25 at 8:01 A.M., the resident said on 6/8/25, he/she left the facility through a door in the dining room. He/She just wanted to leave. He/She walked towards the apartments next to the facility and a staff member found him/her and brought him/her back to the facility. During an interview on 6/11/25 at 2:30 P.M., LPN A said on 6/8/25, the CNA told him/her CNA T saw the resident running towards the apartments next door. The resident told him/her he/she had exited out of a door in the dining room. He/She went to check the two doors in the dining room and the alarm on one of them was very faint and could not be heard outside of the dining room. During an interview on 6/11/25 at 4:01 P.M., CNA T said he/she was on break and getting into his/her car to go and get something to eat. That's when he/she noticed the resident off the facility grounds and in the apartment area (next door to to the facility) walking toward the [NAME] Castle. On 6/10/25 at 10:05 A.M., the Maintenance Di

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure staff documented accurate information in Resident #16's electronic medical record (EMR). On 5/24/25 at 9:15 A.M., Registered Nurse (RN) C documented the resident eloped from the facility and was found on the facility parking lot, despite having knowledge staff were actively searching for the resident. The resident was found approximately 3.7 to 4.7 miles from the facility. The census was 139. Review of the facility Documentation in Medical Record policy, revised on 5/30/25, showed: -Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the residents and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation; -Policy Explanation and Compliance Guidelines; -Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy; -Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred; -Principles of documentation include, but are not limited to: a. Documentation shall be factual, objective, and resident centered; i. False information shall not be documented; b. Documentation shall be accurate, relevant, and complete, containing sufficient details about resident's care and/or responses to care; c. Documentation shall be timely and in chronological order; -Corrections to a medical record shall be made to clarify inaccurate information; -Contradictory information may be clarified by a new entry in the medical record. Review of Resident #16's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/25/25, showed: -Adequate hearing and vision; -Makes Self Understood: Understood; -Ability To Understand Others: Understands; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cognitively intact; -Wandering: Behavior not exhibited; -Diagnoses of diabetes mellitus (high/low blood glucose/sugar), seizure disorder or epilepsy, and schizophrenia; -Any falls since admission or prior assessment: No. Review of the resident's care plan, located in the EMR, showed: -1/19/24: Problem: Resident is at risk of elopement due to having a history of elopement from prior secure facility. Goal: Resident will be monitored closely and remain safe through next review. Interventions: Complete elopement assessments on admission, readmission and quarterly. Face checks/intensive monitoring will be completed per facility protocol. Resident's photo and information will be kept in elopement book; -7/10/24: Problem: Resident has impaired visual function but refuses to wear glasses and refuses to see the eye doctor. -7/10/24: Problem: At risk for the following signs/symptoms related to diagnoses of schizophrenia (a chronic and severe mental disorder that disrupts a person's ability to think, feel, and behave clearly), aggression, and anxiety. Goal: Will have decreased signs and symptoms. Interventions: Avoid arguing or getting defensive with resident. Notify charge nurse if you notice hallucinations, delusions, irritability, talks to self, anxiety or aggression; -9/16/24: Problem: This is resident's safety plan. Goal: Resident's personal goal is: Want to leave. Interventions: The following worked well in the past: listening to jazz music. These are the steps resident wants to make his/her environment safer: be left alone. Review of the resident's progress note, documented by RN C on 5/24/25 at 9:15 A.M., showed: Resident noted to not be in the building at A.M. medication pass. Code white (elopement) called. Resident noted to have pushed his/her way out of the 100 hall door, put chair up to fence and climbed the fence. Resident caught in the parking lot. Returned to facility and placed on 600 hall with one on one. Review of the facility Admin/RN Investigation report dated 5/30/25 at 11:04 A.M., showed: Resident noted not to be in the building during A.M. med pass. Code white was called around 9:15 A.M. The Maintenance Director stated he found the resident at Riverview Circle. He was in the car with two other staff looking for the resident. The resident said he/she left the facility around 5:00 A.M. During an interview on 6/11/25 at 3:03 P.M., RN C reviewed the progress note he/she documented on 5/24/25 at 9:15 A.M. RN C said he/she was aware the resident was not found on the parking lot at the time he/she documented the progress note. The former Assistant Director of Nursing (ADON) told him/her to document the resident was found on the parking lot. When the Director of Nursing (DON) returned from being off (5/22/25 through 5/27/25), she spoke to him/her in her office. She gave him/her verbal counseling about not documenting anything false no matter who tells him/her to do it. He/She should not have documented something he/she knew was not true. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 1:45 P.M., the Maintenance Director confirmed he was in the car with two other staff when they found the resident near Riverside Circle. They found the resident approximately 35 to 45 minutes after the code white was called. During an interview on 6/12/25 at 8:15 A.M., Certified Nursing Assistant N said he/she was with the Maintenance Director when they found the resident at St. [NAME] road and Route 367. Review of Google maps showed the intersection of St. [NAME] road and Route 367 was approximately 3.7 miles to 4.7 miles from the facility, depending on the route the resident walked. During an interview on 6/12/25 at 1:58 P.M., the Administrator said on 5/24/25, he was told by the former ADON the resident was found on the facility campus. Once they investigated the incident, he learned the resident was not found on the facility campus. He would have expected the former ADON to tell him the truth. RN C should not have documented the resident was found on the facility parking lot. He expects staff to follow facility policies.

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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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation and interview, the facility failed to follow their Bloodborne Pathogens/Exposure Control Plan policy by failing to immediately clean and disinfect a potentially infectious blood spill left overnight on one resident's floor (Resident #34). In addition, the facility failed to follow its Handling Clean and Dirty Linen policy when staff failed to place plastic liners inside the designated soiled linen receptacle located in the 100, 200, and 400 shower rooms and did not place the lid back on top of the soiled linen barrel in the 200 and 400 hall shower rooms. The shower room was a community shower. Twenty-five residents were sampled. The census was 145. Review of the facility's Bloodborne Pathogens/Exposure Control Plan dated 4/6/17, and revised on 6/29/23, showed:-This program applies to all occupational exposures to blood or other potentially infectious materials encountered by personnel employed by the Facility;-Employees are grouped according to their risk of exposure according to the following Exposure Categories: Category I - tasks that involve direct exposure to blood, bodily flids, or tissues. Class II - tasks involve no direct exposure to blood, but exposure may occur in an emergency situation. Category III - tasks that do not involve predictable or unpredictable exposure to blood;-Exposure would be likely to occur during exposure to body fluids, or soiled bedding or clothing. This Infection Control Plan shall be effective upon exposure. All requirements of the plan shall be fully implemented prior to this date;-Infection Control: All procedures involving blood or other potential infectious material shall be performed in such a manner as to minimize splashing, spraying or aerosolization of these substances;-Cleaning and Disinfecting: All equipment and environmental and working surfaces shall be properly cleaned and disinfected after contact with blood or other potentially infectious material. This cleaning will be accomplished immediately after treatment is completed;-Infectious Waste Disposal: All infectious waste destined for disposal shall be placed in closeable, leak-proof containers or bags that are color coded or labeled as required. Disposal of all infectious waste shall be in accordance with appropriate federal, state or local regulations;-Laundry: Laundry contaminated with blood or other potentially infectious materials shall be handled as little as possible. Contaminated laundry shall be placed and transported in bags that are labelled and color-coded.Review of the facility's Handling Clean and Dirty Linen policy, copyright 2025, showed: -Purpose: It is the policy of this facility to handle, store, process, and transport clean and soiled linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection; -Definitions: -Linen: Linen includes sheets, blankets, pillows, towels, washcloths, and similar items from departments such as nursing, dietary, rehabilitative services, beauty shops, and environmental services; -Contaminated linen: Contaminated linen is linen that has been soiled with blood or other potentially infectious materials; -Linen can become contaminated with pathogens from contact with intact skin or body substances, or from environmental contaminants or contaminated hands; -Carts will be cleaned when visibly soiled, and routinely according to facility schedule; -Soiled linen: Linen can become contaminated with pathogens from contact with intact skin, body substances, or from environmental contaminants. Transmission of pathogens can occur through direct contact with linens or aerosols generated from sorting and handling contaminated linen. All used linen should be handled using standard precautions (i. e., gloves) and treated as potentially contaminated. Other protective equipment may be required. Examples of linen that may require special handling include, but are not limited to: -Visibly soiled with blood or large amounts of body fluids; -Residents with contagious conditions such as chicken pox, herpes zoster, or other skin legions; -Residents with infectious drainage not contained by dressings or other supplies; -Residents with infections transmitted by contact (e.g., Methicillin-resistant Staphylococcus aureus (MRSA, a strain of bacteria that is resistant to the antibiotic methicillin and other antibiotics in the same class), Vancomycin-resistant Enterococcus (VRE, a type of bacteria that has developed resistance to the antibiotic vancomycin), Clostridioides difficile (C. Diff. Colitis, inflammation of the colon caused by the bacteria clostridium difficile); -Linen should not be allowed to touch the uniform or floor and should be handled as little as possible, with minimum agitation to avoid contamination of air, surfaces, and persons; -Unused or soiled linen shall be collected at the bedside (or point of use, such as dining room) and placed in a linen bag or designated lined receptacle. When the task is complete, the bag shall be closed securely and placed in the soiled utility room; -If linen is heavily soiled, wet, and/or presents a risk of leakage or soaking through, the linen shall be double bagged. Double bagging is also recommended with the outside of the bag is visibly soiled or wet; -Contaminated linen carts should be cleaned and disinfected whenever visibly soiled and according to schedule developed by the facility. 1. Observation and interview on 7/29/25 at 8:18 A.M.