STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295066	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Hills Health Care Center	3450 N Buffalo Dr Las Vegas, NV 89129

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility did not ensure that dishware was sanitized according to food safety protocols in the three-compartment sink area of the main kitchen. This deficient practice had the potential to cause cross-contamination and foodborne illness, affecting all residents who receive meals from the kitchen.Findings include: On 08/12/2025 at 7:45 AM, the Assistant Director of Dietary Services was observed performing a sink sanitizer strip test. The Assistant Director dipped the test strip into the sink with the sanitizer solution for 5 seconds. After 10 seconds, the Assistant Director compared the color of the strip with the color chart on the test strip canister; however, no color change was observed. The test was repeated, but the strip showed no color change, indicating the sanitizer was ineffective.On 08/12/2025 at 8:48 AM, the Director of Dietary Services observed performing the sink sanitizer strip test. The Director dipped the test strip into the sink with the sanitizer solution for 5 seconds. After 10 seconds, when the Director compared the color of the strip with the colors on the test strip canister, it showed a faded brown color. The test was repeated and showed a faded brown color. This result did not meet the minimum manufacturer-required color, indicating a sanitizer concentration of less than 150 parts per million (ppm), whereas the required range is between 200-400 ppm.On 08/12/2025 at 7:51 AM, the Assistant Director was not sure why the test strip was not reading. On 08/12/2025 at 8:50 AM, the Director was not sure why the solution in the sink and test strip was not accurate. The Director confirmed the testing strip measured below the required concentration of the solution in the sink. The facility policy titled Manual Cleaning and Sanitizing, effective February 2017, documented immersion for at least 30 seconds in a sanitizing solution of 220 ppm of quaternary ammonia at 75 degrees Fahrenheit or hotter.

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure psychotropic medication consent forms were obtained and/or updated for 3 out of 39 sampled residents (Resident 12, 14, and 15). The deficient practice had the potential to deny residents the right to be fully informed and to participate in decisions regarding care and treatment.Findings include:1) Resident 12 (R12) was admitted on [DATE] with diagnoses of major depressive disorder, unspecified dementia, unspecified psychosis and traumatic brain injury. A Physician Note dated 06/11/2025 documented to perform a gradual dose reduction for psychotropic medication Quetiapine (an antipsychotic medication) from 400 milligrams (mg) to 300 mg.A Physician Order dated 06/11/2025 documented Quetiapine 300 mg oral tablet give at bedtime for major depressive disorder.The medical record revealed a psychotropic informed consent for Quetiapine 400 mg dated 04/01/2025.The medical record lacked documented evidence informed consent was obtained for the new medication dosage.2) Resident 14 (R14) R14 was admitted on [DATE] with diagnoses including unspecified dementia, anxiety, and schizoaffective disorder. A Psychotropic Informed Consent was signed on 07/07/2025 for Quetiapine 50 mg twice daily for schizoaffective disorder.A Physician Order dated 07/17/2025 documented Quetiapine 100 mg oral tablet twice daily for schizoaffective disorder.The medical record lacked documented evidence a new informed consent was obtained prior to the change in dose.3) Resident 15 (R15) was admitted on [DATE] with diagnoses including schizoaffective disorder, depression, anxiety, and bipolar disorder. A Physician Order dated 08/30/2024 documented Risperdal (an antipsychotic medication) oral tablet 2 mg, give one tablet by mouth at bedtime for schizophrenia. The medical record lacked documented evidence of an informed consent for Risperdal. On 08/19/2025 at 2:00 PM, Licensed Practical Nurse (LPN)1 indicated the nurse would obtain consent for psychotropic medication if the resident was alert and oriented and would explain the risks and benefits of the medication.On 08/19/2025 at 2:15 PM, LPN2 stated there would be a physician order for any psychotropic, if the resident was able to understand the consent form would have the resident sign the form. LPN2 indicated any changes in medication would require a new consent form.On 08/19/2025 at 3:00 PM, the Director of Nursing (DON) indicated any nurse would be able to obtain order and consent for psychotropic medication. The DON verbalized when the medication dose changed a new consent would be obtained. The DON confirmed the changes in dosage for R12 and R14 and a new consent form should have been obtained but was not. The DON confirmed there was no informed consent for the use of Risperdal for R15.The facility policy titled Use of Psychotropic Medication (revised 08/2024) documented residents and/or representatives would be educated on the risks and benefits of psychotropic drug use as well as alternative treatments. Facilities and prescribers should comply with State and Federal requirements pertaining to informed consent.

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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** Based on interview, record review, and document review, the facility failed to ensure a comprehensive care plan was revised to reflect interventions following a fall incident for 1 of 39 sampled residents (Resident 9). The deficient practice had the potential to result in unmet care needs and to increase the risk of additional falls.Findings include: Resident 9 (R9) was originally admitted in 2003, re-admitted on [DATE] with diagnoses including distal tibial impacted fracture and multiple sclerosis.On 08/12/2025 at 1:42 PM, R9 indicated being dependent on staff for care. The resident had fall in January 2025 with fractures. R9 was sitting in a wheelchair and verbalized staff assist resident out of bed and sit in wheelchair during day.The medical record revealed R9 was sent to hospital on [DATE], returned 01/10/2025. The medical record revealed a report was completed for a change in condition (CIC) on 01/05/2025: The CIC evaluation indicated there was a change in skin condition due to swelling and pain in left thigh, left knee, and left foot.The physician was contacted and recommended x-ray and non-weight bearing with left leg.A Progress Note dated 01/05/2025 documented at 10:30 AM, a Certified Nursing Assistant (CNA) called nurse to room to report R9 had complaint of pain to left thigh. Noted left knee and left foot swollen. R9 reported fall from chair on 01/01/2025.The medical record revealed R9 had a care plan for fall risk and included intervention of following facility fall protocol.The medical record lacked documented evidence the care plan was updated with information regarding an actual fall which occurred on 01/01/2025.On 08/14/2025 at 10:19 AM, a Licensed Practical Nurse (LPN) indicated the charge nurse generally updated the care plan when changes or new events occur. The LPN indicated nursing had the ability to update the care plan. The LPN verbalized the care plan should have been updated after fall however it was not completed.On 08/19/2025 at 2:48 PM, the Director of Nursing (DON) verbalized several different disciplines have ability to change or update care plans. Any nurse could update, or any discipline involved could update the care plan. After a change or fall the care plan should be updated to reflect a person-centered approach to care.The facility policy titled Care Plan, Comprehensive (revised [DATE]) documented the purpose was to support and guide resident and interdisciplinary team collaboration to achieve and maintain optimal resident health, function and quality of life. Resident progress was regularly evaluated, and approaches revised or updated as appropriate.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review the facility failed to ensure there were physician orders for the care and maintenance of a central line (a long, flexible tube inserted in a large vein, usually the superior vena cava near the heart) and a peripheral line (a small plastic tube inserted through the skin into a vein of the arm or hand) for 1 of 30 sampled residents (Resident 153). This deficient practice had the potential for an increased risk of infection and to compromise resident health.Findings include: Resident 153 (R153) was admitted on [DATE] and discharged on 08/13/2025 with diagnoses including acute respiratory failure with hypoxia, acute post hemorrhagic anemia, and atherosclerotic heart disease.On 08/12/2025 at 1:21 PM, R153 had a peripheral line located on the back of right hand. The dressing was peeling away and was not dated.On 08/13/2025 at 3:10 PM, R153 was lying in bed with a family member at bedside. The family member explained was unaware why R153 had the peripheral line on the back of the right hand. The family member was aware of a central line located on R153's upper chest. The family member unpinned R153's gown and revealed a central line port to right upper chest intact with sutures and a brownish red stained dressing peeled halfway back from the tubing with an illegible date written in black ink.On 08/13/2025 at 3:15 PM, a Registered Nurse (RN) entered R153's room and stated, I didn't even know [R153] had a central line. The RN was unaware resident had a peripheral line. The RN confirmed the dressing for the peripheral line was peeling off and was undated.On 08/13/2025 at 3:28 PM, the RN confirmed was unable to determine the date written on the dressing for the central line.On 08/13/2025 at 3:40 PM, the RN reviewed R153's medical record and confirmed there were no orders for maintaining the central line and peripheral line such as flushing, dressing change, and observation.On 08/13/2025 at 3:45 PM, the RN explained the process for residents with peripheral or central lines would be to obtain orders for maintenance of the line to include monitoring, flushing, and dressing changes. The RN explained dressings for a peripheral line were changed every three days and the dressing for a central line were to change every seven days. A Physician Order dated 08/13/2025 documented Cefdinir (an antibiotic) 300 milligrams (mg) one tablet twice daily by mouth for 7 days, Lactobacillus twice a day for 10 days, DuoNeb 3 milliliters (ml) every four hours for shortness of breath, and Oxygen at 2 Liters per minute (LPM) via nasal cannula (NC) for Oxygen saturation less than 89%.A Physician Order dated 08/13/2025 documented send resident to emergency room for failure to thrive and pneumonia. A Radiology Report dated 08/13/2025 documented small right basal infiltrate. On 08/14/2025 at 2:34 PM, the Director of Nursing (DON) explained the process for new admissions were when a resident arrived notify the physician, review and verify order with the physician. assess and welcome the residents, complete admission forms, and initiate the care plan. The DON explained the expectation was for licensed nurse to complete daily skilled charting for residents with skilled services. On 08/14/2025 at 2:37 PM, the DON reviewed R153's medical record and confirmed there were no orders for maintenance and daily assessment of the central line or peripheral line. The DON explained the expectation would be for staff to perform a complete assessment and describe the site and status of the dressing. On 08/14/2025 at 2:56 PM, the DON explained not having orders in place could lead to an infection, a central line infection, an embolism, clots, sepsis, or multiple things.On 08/15/2025 at 8:16 AM, R153's Nurse Practitioner (NP) explained when a resident had a central line or peripheral line the expectation for staff was to perform cleaning, flushes, dressing changes and monitoring of the site. The NP explained by not maintaining a central or peripheral line could lead to phlebitis or infections. The NP was aware R153 had a central line and peripheral line but was unaware there were no orders for maintaining the line. The NP confirmed R153 was diagnosed with pneumonia, started on oral antibiotics and discharged .The facility policy titled Catheter Insertion and Care, revised November 2016, documented peripheral intravenous (IV) dressings were changed when needed to prevent catheter related infections associated with contaminated, loosened or soiled catheter site dressings.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure the temperature in a resident's personal refrigerator was monitored for 1 of 30 sampled residents (Resident 97). The deficient practice had the potential for foods to be stored at temperatures which could lead to food borne illness. Findings include:Resident 97 (R97) was admitted on [DATE], with diagnoses including moderate persistent Asthma, chronic obstructive pulmonary disease, hypertensive heart disease, and anemia.On 08/12/2025 in the morning, R97 reported having a mini fridge like machine with yogurt inside for taking medication. R97 disclosed the machine did not keep items cold like a traditional refrigerator.On 08/19/2025 at 12:45 PM, the Assistant Director of Nursing (ADON) went to R97's room and was not able to find a temperature log for the refrigerator. The ADON was not able to locate a thermometer inside the refrigerator. The ADON checked the temperature of the refrigerator which read 64 degrees Fahrenheit. The ADON checked the temperature of the yogurt inside the refrigerator which was 60 degrees Fahrenheit. The facility policy titled Personal Food Storage, effective 09/2014, documented all refrigeration units would have internal thermometers to monitor for safe food and storage temperatures. All units must have maintained safe internal temperature in accordance with state and federal standards for safe food handling. Staff would monitor and document individual room storage and refrigeration units.On 08/19/2025 in the afternoon, the Administrator and the Director of Nursing acknowledged yogurt, at a prolonged temperature greater than 41 degrees Fahrenheit, was not safe for consumption according to state and federal standards for safe food handling.

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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 the medical records were complete and accurate for 3 of 30 sampled residents (Residents 153, 156, and 157). The deficient practice had the potential for residents not to receive timely interventions needed and for the facility missing the opportunity to identify care issues. Findings include: 1) Resident 156 (R156) was admitted on [DATE]. A review of R156's hard chart medical record revealed the following items were missing face sheet, medication administration record (MAR), advanced directives, order summary, and facility history and physical. Only limited laboratory and diagnostic information was available in the hard chart.2) Resident 157 (R157) was admitted on [DATE].The medical record for R157 revealed the following items were missing face sheet, medication administration record (MAR), advanced directives, order summary, and facility history and physical. Only limited laboratory and diagnostic information was available in the hard chart.On 08/13/2025 in the morning, the Medical Records Supervisor confirmed the items missing were required to be included in the hard chart binder. The Medical Records Supervisor verbalized there were no records for the residents of concern stored in the Medical Records Department.On 08/13/2025 at 10:34 AM, a Registered Nurse (RN) indicated if R157 needed to be sent to the hospital, the face sheet, order summary, MAR, advanced directive, facility history and physical, recent and relevant laboratory and diagnostic information along with the hospital discharge summary would be sent with the resident to the hospital. The RN expressed if it were an emergency, the RN would need to call the hospital and provide a verbal report. The RN would inform the hospital additional information would be provided when it was collected since the information was not available in the medical record chart. The RN would have to go to medical records to get the information, but if medical records did not have the information, did not know how to get the information.3) Resident 153 (R153) admitted on [DATE]. On 08/13/2025 at 3:15 PM, an RN was unaware R153 had a central line. The RN reviewed the medical record and confirmed there were no orders for treatments, no face sheet, no advanced directive, no facility history and physical, and limited laboratory and diagnostic information were completed and filed in the resident's paper medical record hard chart.On 08/14/2025 in the afternoon, the Director of Nursing (DON) confirmed the findings and revealed there were no face sheets, no medication administration records (MARs), no advanced directives, no order summaries, no facility history and physicals. The DON explained that the MARs were located on each nurse's medication cart, but the expectation would be for staff to perform resident assessments and file the documentation in the resident's paper medical record hard chart.The facility policy titled Charting and Documentation and Abstract of Medical Records dated 2001, documented the contents of a resident's medical record should contain a history and physical, current diagnosis, treatment records, medication records, nursing notes, dietary notes, care plans, advanced directives, preadmission screen and resident review (PASARR) screenings, and other information as appropriate. Documentation in the medical record would be objective, complete, and accurate so as to facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and document review, the facility failed to ensure a Quality Assurance Performance Improvement (QAPI) plan was in place. This deficient practice has the potential to negatively affect the outcomes of resident care and the quality of each resident's life.Findings include:On 08/19/2025 at 2:08 PM, the Administrator acknowledged the facility did not have a QAPI plan. The Administrator explained the facility was using their QAPI policy as their plan.The facility policy titled Quality Assurance and Performance Improvement (QAPI) Program, revised in February 2020, noted the QAPI committee oversees implementation of the QAPI plan. The QAPI plan described the specifics of the QAPI program, how the facility conducted QAPI functions, and the activities of the QAPI committee. The QAPI plan described the process for identifying and correcting quality deficiencies. The QAPI committee met monthly to review reports, evaluate data, and monitor QAPI-related activities and adjusted the QAPI plan. The QAPI plan was to be presented to the state survey agency annually during the recertification survey.On 08/19/2025 in the afternoon, the Administrator confirmed the facility did not have a specific QAPI plan. The Administrator provided a Quality Assurance & Performance Improvement (QAPI) PowerPoint Presentation which documented the nursing home would have a QAPI Plan which adhered to the core principles of the QAPI Program. The Administrator acknowledged the QAPI policy could be part of the plan, but the plan should be tailored to reflect the specific units, programs, departments, and unique population the facility serves, as identified in the facility assessment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure 1) enhanced barrier precautions were in place for 2 of 39 sampled residents (Resident 60, and 114); 2) staff observed infection control protocols during resident care; and 3) infection prevention and control policies and procedures were reviewed and updated annually. The deficient practice had the potential to result in increased risk of transmission of infectious organisms to residents, staff, and visitors.Findings include: 1) Resident 60 (R60) was admitted to the facility on [DATE] with diagnoses of gastrostomy and cerebral infarction affecting the left non-dominant side. On 08/13/2025 at 3:15 PM, R60 had a feeding tube. There were no signs on or around the resident's door indicating Enhanced Barrier Precautions (EBP). Staff were observed providing care without wearing Personal Protective Equipment (PPE). On 08/13/2025 at 3:54 PM, a Registered Nurse (RN) acknowledged EBP signage should have been posted on the door to inform staff R60 had feeding tube. The RN emphasized that when providing care related to the feeding tube, it was important for staff to wear gowns and gloves due to the potential for liquid splashing, to ensure proper protection. On 08/13/2025 at 4:09 PM, the Director of Nursing (DON) indicated when a resident had an enteral access site for a feeding tube Enhanced Barrier Precautions (EBP) sign should be posted on the resident's door. The DON acknowledged staff were required to wear a gown and gloves when providing care for residents with a feeding tube, as part of infection control protocols. On 08/18/2025 at 4:22 PM, the Infection Preventionist (IP) stated R60 should have had an EBP sign posted on the door. The IP confirmed awareness of the EBP requirements and explained the facility was currently evaluating all residents on contact precautions due to recent staff changes. The IP acknowledged staff were required to wear gloves and a gown when providing care to residents receiving enteral nutrition via gastrotomy tube, to ensure protection for both staff and residents. Resident 114 (R114) was admitted to the facility on [DATE] with diagnoses of hypertensive chronic kidney disease and Type 2 diabetes mellitus. On 08/13/2025 at 10:50 AM, R114 was observed to have a dialysis shunt in the chest. There was no signage on the resident's door indicating Enhanced Barrier Precautions (EBP). Staff were observed providing care without wearing PPE. On 08/15/2025 at 8:48 AM, a Licensed Practical Nurse (LPN) was observed wearing gloves to access R114's dialysis site. The LPN removed the dressing covering the dialysis line (right subclavian), then removed gloves without performing hand hygiene. The LPN exited the room to retrieve a new dressing, re-entered, put on new gloves, applied the dressing, and removed gloves without performing hand hygiene. The LPN did not wear a gown during the procedure. The LPN confirmed hand hygiene had not been performed when changing gloves while applying the new dressing. The nurse acknowledged the importance of hand hygiene in preventing infection and maintaining cleanliness. The LPN did not cleanse the site before applying the new dressing. The LPN stated failure to perform proper hand hygiene presents a significant risk for infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/15/2025 at 10:23 AM, the Infection Preventionist (IP) stated Enhanced Barrier Precautions (EBP) signage should have been posted on the doors of residents receiving dialysis care. The IP confirmed that when nurses were checking a resident's dialysis access site, the nurse was required to wear a gown and gloves. The IP acknowledged after completing care, nurses would remove the gloves and gown and perform hand hygiene using either soap and water or an alcohol-based hand sanitizer. The IP emphasized failure to perform hand hygiene after providing care increases the risk of infection. On 08/15/2025 at 1:20 PM, the Director of Nursing (DON) stated residents with a dialysis access site must have Enhanced Barrier Precautions (EBP) signage posted at the door. The DON indicated that when staff were providing care, they must wear a gown and gloves. The DON confirmed after completing care, staff must perform hand hygiene following the removal of gloves and gown either by washing hands with soap and water or using hand sanitizer gel. The DON acknowledged performing proper hand hygiene was essential in preventing infection. The facility policy titled Infection Prevention Manual for Long-Term Care (Enhanced Barrier Precautions), revised in May 2024, documented an order for Enhanced Barrier Precautions should be obtained for residents with indwelling medical devices such as central lines or feeding tubes even if the resident had not been known to be infected or colonized with a multidrug-resistant organism (MDRO). The policy documented that implementation of Enhanced Barrier Precautions included making gowns and gloves immediately available near or outside of the resident's room. The facility policy titled Hemodialysis, implemented on December 2022, stated staff would ensure appropriate PPE was worn and follow current infection control practices when assessing dialysis access site. 2. On 08/14/2025 at 10:24 AM, room [ROOM NUMBER] had a contact precaution sign on door, housekeeping staff in room mopping the floor with mask and gloves as the only personal protective equipment (PPE). The housekeeping staff member explained the sign indicated when staff had contact with residents the staff would be required to have a gown as well as the other personal protective equipment. On 08/14/2025 at 10:45 AM, room [ROOM NUMBER] had a contact precaution sign on the door. Housekeeping staff were outside the room, staff member entered the room without putting on a gown, gloves were the only PPE worn. The staff member entered the resident bathroom and exited approximately one minute later and went to cart in hallway. The staff member retrieved an item from the cart and returned to the resident room without removing gloves or performing hand hygiene. On 08/14/2025 at 10:46 AM, Housekeeper2 indicated the resident in B bed was on precautions and indicated gown, gloves should be used and Houskeeper2 forgot to put on proper PPE. On 08/14/2025 at 10:50 AM, room [ROOM NUMBER] had a contact precaution sign on door. A resident in the room was talking with a staff member who was not wearing any PPE. The staff member was identified as the Laundry Supervisor and verbalized the contact precaution sign indicated that any person entering the room should put on gloves and gown. The Laundry (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Supervisor explained the contact precaution sign was updated from enhanced barrier precaution on the previous day and verbalized it was the staff responsibility to read the sign. On 08/15/2025 at 1:02 PM, the Infection Preventionist (IP) indicated starting position approximately one week ago and was updating protocols and providing education as needed to staff regarding the use of PPE and difference between contact precautions and enhanced barrier precautions. The IP indicated contact precautions required all staff regardless of resident contact to wear PPE. Enhanced barrier precautions required staff wear PPE if performing a high-risk procedure such as changing catheter or providing wound care. Observations of staff in contact isolation rooms were shared, and the IP indicated the staff did not meet the expectations of proper infection control practices. The facility policy titled Companion Guidance and Resources (revised May 2024) documented resources for staff when encountering contact precautions or enhanced barrier precautions. The document included information on proper use of PPE and handwashing. 3. The infection prevention manual documented the last review, or update was May of 2024. On 08/15/2025 at 1:02 PM, the Infection Preventionist (IP) provided the Infection Prevention Manual for Long Term Care. The IP indicated it was used to formulate policy, procedures, and protocols for all infection control practices at the facility. The IP acknowledged the revision date on the documents was May of 2024. The IP confirmed it was what the facility was currently using. The Director of Nursing was not able to provide any further information on the latest update to the infection control policies and procedures.