STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335532	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aaron Manor Rehabilitation and Nursing Center	100 St Camillus Way Fairport, NY 14450

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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 - Few	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. 34459 Based on observations, interviews, and record review conducted during a Recertification Survey from 10/17/2024 to 10/24/2024, for one of one kitchen, the facility did not provide housekeeping and maintenance services necessary to maintain a clean, comfortable, and homelike environment. Specifically, there was wall damage that was previously identified but not repaired. The findings are: The facility policy Healthcare Services Group, Inc. and its subsidiaries HCSG Policy 028, revised 09/2017, included all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. The Dining Service Director will ensure that the kitchen in maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. During observations on 10/17/2024 at 9:06 AM, there was an approximately 8-inch hole through the base of the wall behind the dish machine that was in disrepair. During an interview at this time, the Food Service Director stated the baseboard hole had been like that for a year. During an interview on 10/17/2024 at 2:50 PM, the Maintenance Director stated the wall behind the dish machine had been an issue for some time. There were quotes out to get it repaired and there was water damage inside the wall. During an interview on 10/18/2024 at 12:29 PM, the Food Service Director stated it had been six months since the wall was broken through by water damage, and the wall behind the kitchen also had damage. The Food Service Director also stated there were quotes and work orders out, and there had been fruit flies at times in that area. 10 NYCRR: 415.29, 415.29(j)(1), 10 NYCRR: 415.14(h), Subpart 14-1.171

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 49368 Based on observations, interviews, and record review conducted during the Recertification Survey from 10/17/2024 to 10/24/2024, the facility did not ensure residents were assessed for safe use of bed (side) rails prior to installation, did not review the risks and benefits of bed rails with the resident or resident representative, and did not obtain informed consent prior to the installation of bed rails for 6 of 12 residents (Resident #13, #42, #49, #107, #112 and #128) reviewed for accidents. Specifically, the residents were observed, in bed with bed rails of different types in use and no evidence that assessments had been completed or updated to ensure the safety of the bed rails, that the risks and benefits of the bed rails had been provided to the resident or their representative, or that consent had been obtained physician orders obtained prior to installation. In addition, the residents were not care planned for the bed rails in use. The evidence includes but not limited to the following: The undated facility policy Assist Rails included the purpose of the guidelines is to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms. An assessment will be made to determine the resident's symptoms and reason for using side rails, an assessment will include a review of the resident's bed mobility, ability to transfer between positions, education to resident or representative on risk versus benefit, and risk for injury or ability to use safely. The use of assist rails as an assistive device will be addressed in the resident care plan. Resident and/or designated representative will be informed of Interdisciplinary Team recommendations. The procedure includes a therapy evaluation for bed mobility, therapy will determine the type and use of assist rail based on evaluation, update care plan to reflect assist rail use, and reevaluate appropriateness of use when or if the resident has a change in condition. 1. Resident #13 had diagnoses including dementia, essential tremor (a neurological disorder that causes involuntary rhythmic shaking), and anxiety. The Minimum Data Set Resident Assessment, dated 09/10/2024, included the resident was moderately cognitively impaired, required substantial/maximal assistance to roll left and right in bed and was dependent on staff for transfers. Review of Resident #13's Side Rail Assessment, completed 05/04/2023, revealed that side rails were indicated and Resident #13 was able to demonstrate safe use of the bed rails. Review of Resident #13's current (prior to surveyor intervention) Comprehensive Care Plan last revised on 05/03/2024, revealed the resident had a self-care performance deficit for activities of daily living related to dementia and that the resident may use one half upper bed rail. On 09/19/2024, the Comprehensive Care Plan was revised to include the resident was dependent on two staff for transfers using a mechanical lift. During observations on 10/17/2024 at 4:09 PM, 10/18/2024 at 8:10 AM, and 10/21/2024 at 6:48 AM, the resident was in bed with bilateral half bed rails in use on the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/21/2024 at 12:35 PM, the resident was in bed with two half bed rails in place. The resident's oxygen tubing was wrapped within one of the half bed rails and the oxygen nasal prongs (delivers the oxygen via the nares) were dislodged. The facility was unable to provide any further assessments completed since 05/04/2023 that risks and benefits were reviewed with the resident and/or their representative, or that consent was obtained. 2. Resident #128 had diagnoses including dementia, cerebral infarction (stroke), and peripheral neuropathy (nerve damage that affects the hands and feet). The Minimum Data Set Resident Assessment, dated 09/01/2024, included the resident was severely impaired cognitively, required partial/moderate assistance to roll left and right in bed, and was dependent on staff for transfers. Review of Resident #128's current (undated) Comprehensive Care Plan revealed the resident had a self-care performance deficit for activities of daily living related to confusion, dementia, fatigue, impaired balance, limited mobility, and stroke. Interventions included that the resident was independent to roll left and right in bed and required substantial/maximal assistance of staff for transfers. During observations on 10/18/2024 at 8:00 AM and 10/21/2024 at 11:34 AM Resident #128 was in bed. Bilateral enabler bars were in use on the bed. Review of Resident #128's electronic health record revealed no assessments for the safe use of any type of bed rail or risk of entrapment, no evidence that the risks and benefits of bed rails had been reviewed with the resident or resident representative, or consent obtained. 3. Resident #112 had diagnoses including dementia, psychosis, and anxiety. The Minimum Data Set Resident Assessment, dated 08/09/2024, included the resident was severely impaired cognitively, was independent to roll left and right in bed and required supervision or touching assistance for transfers. Review of Resident #112's current (undated) Comprehensive Care Plan revealed the resident had a self-care performance deficit for activities of daily living related to dementia. Use of bed rails was not included on the care plan. During observations on 10/18/2024 at 8:30 AM and on 10/21/24 at approximately 6:38 AM Resident #112 was in bed. Two enabler bars were in use on the bed. Review of Resident #112's electronic health record revealed no assessments for the safe use of bed rails or risk of entrapment, no evidence that the risks and benefits of bed rails had been reviewed with the resident or resident representative, or consent obtained. 4. Resident #107 had diagnoses including cerebral infarction (stroke), dementia, and anxiety. The Minimum Data Set Resident Assessment, dated 09/09/2024, included the resident was severely impaired cognitively, had impairment in range of motion on both sides of the lower extremities (hip, knee, ankle, foot), and was dependent on staff to roll left and right in bed and for transfers. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #107's Side Rail Assessment, completed 05/01/2024, revealed that the resident could not demonstrate safe use of the bed rails and that bed rails were not indicated. Review of Resident #107's current (undated) Comprehensive Care Plan revealed the resident had a self-care performance deficit for activities of daily living. Interventions included that the resident was dependent on staff for rolling right and left in bed and for transfers using a mechanical lift. The care plan also included effective 08/22/2024, the resident used one half upper bed rail. Review of Resident #107's electronic health record revealed no updated assessments for the safe use of bed rails or risk of entrapment, no evidence that the risks and benefits of bed rails had been reviewed with the resident or resident representative, or consent or physician order obtained. During observations on 10/17/2024 at 10:10 AM, 10/18/2024 at 8:22 AM, and 10/21/2024 at approximately 6:58 AM, Resident #107 was in bed. Bilateral half bed rails were in use on the bed and there were no staff in the room. During an interview on 10/18/2024 at 9:23 AM, Certified Nursing Assistant #6 stated the bed rails were on Resident #107's bed so they could help us (facility staff) turn the resident. During an interview on 10/23/2024 at 10:36 AM, Licensed Practical Nurse Manager #2 stated that residents were assessed by therapy to make sure they were appropriate for bed rails, and all residents who have bed rails should have a bed rail assessment done quarterly. The facility only uses bed rails for bed mobility and residents would have to be able to understand the use of bed rails. Licensed Practical Nurse Manager #2 stated Resident #107 was not cognitively intact, staff should lower the bed rails for the resident, and only utilize the bed rails while staff were in the room providing care so the resident can participate. Bed rails were not used at night or when staff were not in the room with the residents. During an interview on 10/22/2024 at 11:49 AM, Licensed Practical Nurse #3 stated therapy has to approve a bed rail and a physician order would be needed. Licensed Practical Nurse #3 said staff could have the bed rail up for residents to use during care but then it should be lowered. Staff should look at the Kardex (care plan used by the Certified Nursing Assistants for daily care) to see if bed rails should be used. Licensed Practical Nurse #3 stated that the staff may have put them up to let the resident use them and then forgot to put them back down. During an interview on 10/22/2024 at 12:11 PM, Licensed Practical Nurse Manager #3 stated that a resident should be able to use bed rails for mobility, they should be assessed, and care planned for and have a physician order. Licensed Practical Nurse #3 said that many bed rails were recently put down as some of the residents had not been assessed correctly. During an interview on 10/23/2024 at 10:05 AM, Maintenance Supervisor #1 stated they had calls about some of the bed rails being up and residents not knowing how to release them. During an interview on 10/23/2024 at 10:11 AM, Physical Therapist Assistant #1 stated that bed rail assessments were in the assessment tab (in the resident's electronic health record) and were completed by therapy quarterly. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/23/2024 at 10:13 AM, Director of Rehabilitation stated if there was no bed rail assessment in the resident's assessment tab then a bed rail (including enabler bars) had not been assessed by therapy. They also stated it had recently been brought to the attention of the therapy department that multiple residents had bed rails. The Director of Rehabilitation stated that they did a building-wide audit to ensure residents were appropriately care planned for bed rails and stated to their knowledge residents must be assessed for safety prior to using bed rails or the enablers. Staff should not raise them for a resident to use if not assessed. During an interview on 10/23/2024 at 10:47 AM, the Director of Nursing stated bed rails, side rails, and enablers were used for mobility only, an assessment should be done by therapy and added to the resident's care plan. A resident should not have them up if an assessment had not been completed. The Director of Nursing stated education should be provided to ensure that a resident was capable of using it for mobility and it was safe. During an interview on 10/23/2024 at 11:19 AM, the Administrator stated therapy should complete an assessment and staff should take their guidance if it was going to be useful for a resident or not. They also stated it is not our standard practice for a resident to have one up (bed rail) if they had not been assessed and deemed appropriate. The Administrator stated if a resident was not assessed the resident could be at risk for injury or entrapment; our process was that residents required a therapy assessment prior to use and on the care plan. Staff should not raise the bed rails to use and put back down. 10 NYCRR 415.12(h)(1)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 46880 Based on observations, interviews, and record review conducted during the Recertification Survey from 10/17/2024 to 10/24/2024, for two (Resident #73 and #96) of five residents reviewed, the facility did not ensure a medication error rate of five percent or less. There were two medication errors for 27 opportunities resulting in a medication error rate of 7.4 percent. Specifically, a narcotic pain medication was signed for but not administered until eight hours after its scheduled time. A second medication was pre-poured that was not labeled as to what it was or who it was for and the medication nurse was not aware of what the medication for for or where to apply it. This is evidenced by the following: The facility policy Medication Administration, revised on 08/12/2024, documented the individual administering the medication shall verify the medication selected for administration is the correct medication based on the medication order and the medication product label. The individual administering a medication shall be aware of the following information concerning each medication before administration: route and frequency of administration and the appropriate timing of medication administration. 1. Resident #96 had diagnoses that included a right femur fracture, multiple rib fractures, spinal fractures, and dementia. The Minimum Data Set Resident Assessment, dated 09/25/2024, documented the resident had moderately impaired cognition and received scheduled pain medications. Review of a physician's order, dated 10/07/2024, included hydrocodone 20 milligrams every morning for pain. During a medication administration observation on 10/21/2024 at 11:14 AM, hydrocodone 20 milligrams was not included with the medications Licensed Practical Nurse Manager #1 administered to Resident #96. Review of the October 2024 Medication Administration Record revealed the hydrocodone dose scheduled on 10/21/2024 at 8:00 AM was signed as administered. During an interview on 10/21/2024 at 2:17 PM, Licensed Practical Nurse Manager #1 stated they had not administered the hydrocodone dose because they did not see it on the Medication Administration Record but may have accidentally signed as administered prior. 2. Resident #73 had diagnoses including rosacea (a condition that causes facial redness), multiple sclerosis, and depression. The Minimum Data Set Resident Assessment, dated 10/16/2024, documented the resident was cognitively intact. Review of current physician orders included clobetasol external cream 0.05% apply to the labia (vaginal area) topically two times daily (initiated 09/25/2024), and ketoconazole external cream 2% apply to the face topically twice daily (initiated 09/12/2024). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/21/2024 at 11:31 AM, in a drawer of the medication cart in the 300 resident hall there was a medication cup that contained a pre-poured cream. The cup was unlabeled as to what was in it or who it was for. During an interview at the time, Licensed Practical Nurse Manager #1 stated they had already given Resident #73 their pills, that the cream had been pre-poured and signed as administered, but they intended to administer it later. Licensed Practical Nurse Manager #1 stated the cream was ketoconazole 2% for Resident #73's face. Licensed Practical Nurse Manager #1 provided the original container for the medication, which was clobetasol 0.05% cream and was ordered for the resident's labia. During an interview on 10/21/2024 at 2:57 PM, the Director of Nursing stated narcotic pain medications should be given on time (one hour before or after the scheduled time) and the electronic medication administration record was programmed to indicate when medications were late to avoid missed opportunities to administer a medication. The Director of Nursing stated all medications should remain in their original packaging until the time it was administered, and nurses should only sign that a medication had been administered at the time it was being administered. 10 NYCRR 415.12(m)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46880 Based on observations, interviews, and record review conducted during the Recertification Survey from 10/17/2024 to 10/24/2024, for one (3-400 Unit) of two medication storage rooms reviewed, the facility did not ensure that all drugs and biologicals were properly stored in accordance with State and Federal Laws. Specifically, the 3-400 Unit controlled medication (medications whose possession and use of are regulated by the government due to their potential for serious side effects) cabinet, contained several blister packs of controlled medications that were secured with one locked door (versus two). The exterior door of the cabinet was unlocked. This is evidenced by the following: The undated facility policy Center Medication Storage Policy included that schedule II-controlled medications are maintained within a separately locked permanently affixed compartment. They are stored in a double-locked environment such as a locked medication room in a locked narcotic cabinet, or locked narcotic box in a locked medication cart in use. The facility policy Controlled Drug Management, dated February 2024, included the controlled substances storage area on each resident care unit must be kept double locked and secured at all times when not in use. During an observation on 10/17/2024 at 12:16 PM in the 3-400 Unit medication storage room, the outer controlled cabinet door was unlocked, and several blister packs of controlled medications were secured only by the locked interior door. During an interview on 10/17/2024 at 12:18 PM, Licensed Practical Nurse #2 stated they must have forgotten to lock the exterior cabinet door. During an interview on 10/23/2024 at 11:24 AM, the Director of Nursing stated controlled medications should not be stored in a cabinet that is not double-locked. All controlled cabinets in the facility had two locks and they would expect the cabinets to be double-locked at all times. 10 NYCRR 415.18(e)(1-4)

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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. 47642 Based on observations, interviews, and record review conducted during the Recertification Survey from 10/17/2024 to 10/24/2024, for four (Residents #11, #13, #51 and #61) of 11 residents reviewed, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections. Specifically, two Certified Nursing Assistants did not wear the appropriate personal protective equipment (equipment used to prevent or minimize exposure and transmission of diseases/infections) when transferring a resident on enhanced barrier precautions (an infection control practice that involves wearing gloves and gowns during high-contact patient care activities). One of the Certified Nursing Assistants did not wash their hands after transferring the resident prior to assisting another resident with care. Additionally, a used insulin (medication used to treat diabetes) syringe was observed on a resident's bedside table, nasal cannula (device used to deliver extra oxygen) prongs were inserted into a resident's nose by a staff member after being found on the floor and prior to cleaning (or changing), and an unattached used indwelling urinary catheter (a tube that drains urine from the bladder into a drainage bag) tubing filled with uring was lying on the floor. A yellow urine looking liquid was on the floor underneath it. This is evidenced by the following: The facility policy Enhanced Barrier Precautions, dated 07/02/2024, documented enhanced barrier precautions involved gown and glove use during high-contact resident care activities for residents that were known to be colonized or infected with a Multidrug-Resistant Drug Organism (MDRO) and for residents with wounds or indwelling medical devices. Staff should perform hand hygiene when switching care from one resident to another. 1. Resident #61 had diagnoses including klebsiella pneumoniae (a bacterial infection) urinary tract infection, acute kidney failure with obstructive uropathy (obstructed urinary flow), and sepsis (infection that can lead to tissue damage or organ failure). The Minimum Data Set Resident Assessment, dated 10/08/2024, documented the resident was cognitively intact and had a urinary catheter or urinary ostomy (an opening in the abdomen to divert urine away from a non-functioning bladder). Review of a physician's order, dated 10/18/2024, documented enhanced barrier precautions and to ensure gloves and gown are worn with care or any other extended duration of close contact care to include, but not limited to, transfers. Review of Resident #61's Comprehensive Care Plan, dated 10/02/2024, revealed Resident #61 was at risk for a Multidrug-Resistant Organism transmission or infection related to having a chronic (long term) indwelling urinary catheter and nephrostomy tube. Interventions included, but were not limited to, enhanced barrier precautions and staff to wear gown and gloves with all direct close contact care including transfers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/22/2024 at 11:11 AM, Certified Nursing Assistants #4 and #5 were rolling Resident #61 in bed to put a transfer sling under the resident's body. A yellow gown magnet was stuck to the resident's door frame. There was no sign indicating the resident was on Transmission Based Precautions. Both Certified Nursing Assistants were wearing gloves, neither were wearing a gown. Certified Nursing Assistant #4 removed their gloves, did not cleanse their hands, and left the room returning a few minutes later with a mechanical lift. Certified Nursing #4 did not wear gloves while assisting the resident into the mechanical lift or maneuvering the resident into the Geri-chair. Resident #61 was assisted across the hall into the sunroom and Resident #15 requested assistance at that time. Certified Nursing Assistant #4 pushed Resident #15's wheelchair into their bathroom and closed the bathroom door. Certified Nursing Assistant #4 did not perform hand hygiene after completing Resident #61's care or before assisting Resident #15. During an interview on 10/22/2024 at 11:20 AM, Certified Nursing Assistant #4 stated they knew the resident was on enhanced barrier precautions but did not think they had to wear a gown when transferring the resident. Certified Nursing Assistant #4 stated they did not wash their hands in between assisting Residents #61 and #15, but did wash them while in Resident #15's room. 2. Resident #51 had diagnoses including cerebral vascular accident (stroke), diabetes, and hypertension. The Minimum Data Set Resident Assessment, dated 10/10/2024, documented the resident had moderately impaired cognition and received insulin injections. During an observation on 10/17/2024 at 9:21 AM, there was a used insulin syringe with the needle capped on Resident #51's bedside table next to their breakfast tray. 3. Resident #13 had diagnoses including dementia, heart failure, and hypoxemia (low levels of oxygen in the blood). The Minimum Data Set Resident Assessment, dated 09/10/2024, documented the resident had moderately impaired cognition and received oxygen therapy. The facility policy Oxygen Administration, dated 07/12/2023, documented all oxygen tubing and cannulas used to deliver oxygen should be changed weekly, when visibly soiled, or as needed. Physician orders, initiated 6/17/2024 included Resident #13 required continuous oxygen via nasal cannula for low oxygen levels and for staff to change the tubing weekly. During an observation on 10/21/2024 at 12:35 PM, Resident #13 was sitting up in bed, the oxygen concentrator was on, and the nasal cannula prongs were lying directly on the floor. At 12:39 PM, Licensed Practical Nurse Manager #2 put the nasal cannula prongs that had been lying on the floor into Resident #13's nose. 4. Resident #11 had diagnoses including obstructive uropathy, congestive heart failure, and diabetes. The Minimum Data Resident Assessment, dated 08/23/2024, documented the resident was cognitively intact and had an indwelling catheter. The facility policy Catheter Care, dated 01/19/2024, included but not limited to that the positioning of the catheter tubing and urinary drainage was very important and should never touch the floor. (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	During an observation on 10/17/2024 at 10:40 AM, Resident #11 was in bed. The unattached urine collection bag was hanging on the bed frame and the urinary tubing extending from the collection bag was lying on the floor The tubing contained urine and there was urine like yellow liquid on the floor. During an interview on 10/23/2024 at 11:01 AM, the Infection Control Nurse stated staff should wear gown and gloves when in close contact with a resident on enhanced barrier precautions, including transfers. An insulin syringe should be disposed of in a sharps container (a receptacle for safe disposal of sharp objects, including syringes, to limit exposure and spread of bloodborne pathogens) and not left on the resident's bedside table. The Infection Control Nurse also stated the urine collection bag and tubing should have been disposed of and not lying on the floor. The Infection Control Nurse stated nasal prongs should not be inserted into a resident's nose after coming in contact with the floor, and all of these issues were infection control concerns. During an interview on 10/23/2024 at 10:47 AM, the Director of Nursing stated staff should wear a gown and gloves when transferring a resident on enhanced barrier precautions as they would have to be in close contact with the resident to put the sling underneath them. Handwashing should be performed in between caring for one resident and another. The Director of Nursing stated the insulin syringe should have been disposed of in the sharps container immediately after use and a urine collection bag and tubing should never be in contact with the floor. The Director of Nursing stated these issues were infection control concerns due to the potential for contamination and spreading of germs and infectious diseases. 10 NYCRR 415.19(a)(1-3) (b)(4)