STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335840	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medford Multicare Center for Living	3115 Horseblock Road Medford, NY 11763

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observations, record review, and interviews during the Recertification Survey initiated on 2/24/2025 and completed on 2/28/2025 the facility did not ensure that a Baseline Care Plan for each resident included instructions needed to provide effective person-centered care that meets professional standards of quality care. This was identified for one (Resident #519) of three residents reviewed for Infection Control. Specifically, Resident #519 was admitted with Coronavirus (COVID-19) positive infection and had a physician's order for Droplet and Contact Precautions for ten days. There was no care plan developed and implemented for the Droplet and Contact Precautions. The finding is: The facility's policy, titled Person-Centered Care Plan last reviewed 10/2024 documented upon admission the facility shall conduct a comprehensive Person-Centered Care Plan, including an accurate assessment of each resident's functional capacity. All care planning begins upon admission. The care of each resident will be delivered according to the identified goals and interventions of the Comprehensive Care Plan. The Care Plan is developed within seven (7) calendar days from the admitted after completing the comprehensive assessment. Resident #519 was admitted with diagnoses including Coronavirus (COVID-19) infection, Rhabdomyolysis (medical condition where skeletal muscles break down), and Alzheimer's Disease. Resident #519 was recently admitted to the facility and did not have a Minimum Data Set assessment completed. The admission physician's order dated 2/20/205 documented Droplet/Contact precautions during every shift for Coronavirus (COVID-19) infection for 10 days. The order was discontinued on 2/27/2025. The Social Work Admission assessment dated [DATE] documented a Brief Interview for Mental Status score of 8, indicating the resident had moderate cognitive impairment. A review of Resident #519's electronic medical record revealed there was no documented evidence of a care plan for Droplet and Contact Precautions. During an observation on 2/24/2025 at 8:23 AM, Resident #519 was observed in bed unable to answer interview questions. A Droplet and Contact Precautions sign and a cart with Personal Protective Equipment was placed outside the resident's room door. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/2025 at 10:10 AM, Registered Nurse Clinical Care Coordinator #1 stated the Infection Preventionist removed the contact sign today because Resident #519's isolation was discontinued. Registered Nurse Clinical Care Coordinator #1 stated today was day 11 since the resident had a positive Coronavirus (COVID-19) test result. Registered Nurse Clinical Care Coordinator #1 stated they were not aware that Resident #519 did not have a care plan for Droplet and Contact Precautions, and they should have initiated the care plan when the resident was first admitted . Registered Nurse Clinical Care Coordinator #1 stated the admission nurse, the Infection Preventionist, or themselves could have developed the care plan. During an interview on 2/27/2025 at 10:49 AM, Registered Nurse Infection Preventionist #1 stated when a resident is placed on Droplet and Contact Precautions, a care plan should be developed with individualized goals and interventions. Registered Nurse Infection Preventionist #1 stated they were unsure why Resident #519 did not have a care plan for Droplet and Contact Precautions. Resident #519 was placed on Droplet and Contact precautions because they (the resident) came from the hospital with Coronavirus (COVID-19) infection. The facility discontinues the Droplet and Contact precautions after 10 days based on the hospital diagnosis from 2/15/2025. During an interview on 2/28/2025 at 1:29 PM, the Director of Nursing Services stated care plans should be developed timely and accurately. The Director of Nursing Services stated the admission nurse should have created a care plan upon admission because Resident #519 was admitted with a positive Coronavirus infection and was placed on Contact and Droplet Precautions. 10 NYCRR 415.11

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observations, record review, and interviews during the Recertification Survey initiated on 2/24/2025 and completed on 2/28/2025 the facility did not ensure parenteral fluids were administered consistent with current professional standards of practice, physician orders, and the comprehensive person-centered care plan. This was identified for one (Resident #242) of three residents reviewed for Hydration. Specifically, Resident #242 was admitted to the facility with a Peripheral Inserted Central Catheter (PICC) in their right arm from the hospital. There was no documentation the facility was Monitoring the Peripheral Inserted Central Catheter (PICC) site or measuring the length of the external catheter. The finding is: The facility's policy titled Peripheral Inserted Central Catheter (PICC) line last reviewed 6/2024, documented to assess the insertion site and surrounding tissue for any inflammation, tenderness, or drainage and if observed, report the findings to the physician. The policy did not include guidance for measuring the external catheter for the Peripheral Inserted Central Catheter (PICC). Resident #242 was admitted with diagnoses that include Kidney Stones and Sepsis. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 8, which indicated the resident had moderate cognitive impairment. The Minimum Data Set assessment documented Resident #242 had intravenous access and received intravenous antibiotics. The Patient Review Instrument (an assessment tool used to determine patient placement) dated 1/31/2025 documented Resident #242 had a Peripheral Inserted Central Catheter (PICC) placed in their right arm on 1/29/2025. A physician's order dated 1/31/2025 documented to flush the Peripheral Inserted Central Catheter (PICC) with 10 milliliters of Normal Saline every shift **RN ONLY.** A physician's order dated 2/01/2025 documented Cefepime Intravenous Solution (an antibiotic) use 2 grams intravenously every 12 hours for Sepsis due to Serratia & Pseudomonas infection until 3/02/2025. The Comprehensive Care Plan dated 2/12/2025, developed after 12 days the resident was admitted to the facility, documented Resident #242 had a Peripheral Inserted Central Catheter (PICC) for intravenous antibiotics administration. Interventions included monitoring the site every shift and as needed. A physician's order dated 2/25/2025 documented to monitor the Peripheral Inserted Central Catheter (PICC) line site each shift, and notify the Physician of any redness, tenderness, edema, or excessive bleeding. The order did not include measuring the Peripheral Inserted Central Catheter (PICC) line length externally to monitor the migration of the catheter. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration Record for February 2025 indicated no documented evidence that the Peripheral Inserted Central Catheter (PICC) was assessed or measured each shift from 2/1/2025 to 2/24/2025. The Treatment Administration Record for February 2025 indicated no documented evidence that the Peripheral Inserted Central Catheter (PICC) was assessed or measured each shift from 2/1/2025 to 2/24/2025. During an observation and interview on 2/25/2025 at 8:50 AM, Resident #242 was sitting in bed having breakfast. A Peripheral Inserted Central Catheter (PICC) line was observed on the right arm. Resident #242 stated the Peripheral Inserted Central Catheter (PICC) line was for administering the antibiotics. During an interview on 2/26/2025 at 2:25 PM Registered Nurse Clinical Care Coordinator #1 stated this resident came from the hospital with the Peripheral Inserted Central Catheter (PICC) in place. They stated there was no order to measure the Peripheral Inserted Central Catheter (PICC) external catheter or for the assessment of the Peripheral Inserted Central Catheter (PICC) daily. The Peripheral Inserted Central Catheter (PICC) line should be monitored each shift, and the external catheter should be measured weekly to ensure the catheter did not migrate causing infiltration, or the medication not being delivered. The nurse who admitted the resident should have made sure the order was in place. Clinical Care Coordinator #1 stated they should have made sure that a care plan was in place. During an interview on 2/28/2025 at 8:39 AM, the Registered Nurse Educator stated the order should state the nurse should measure the external catheter length during a dressing change and document the length in the Medication Administration Record or the Treatment Administration Record. During an interview on 2/28/2025 at 12:35 PM, Licensed Practical Nurse #1 stated they do not provide Peripheral Inserted Central Catheter (PICC) line care. The Registered Nurses are responsible for completing the task including flushing the Peripheral Inserted Central Catheter (PICC) line, and hanging the antibiotic medications on the Peripheral Inserted Central Catheter (PICC). Licensed Practical Nurse #1 stated when the Registered Nurse completes their task they (Licensed Practical Nurse #1) then document on the Medication Administration Record that the task was completed. During an interview on 2/28/2025 at 1:26 PM, the Director of Nursing stated the facility policy did not include measuring the external catheter length for the Peripheral Inserted Central Catheter (PICC). The staff should have monitored and documented their findings each shift. 10 NYCRR 415.12(k)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44925 Based on observations, record review, and interviews during the Recertification Survey initiated on 2/24/2025 and completed on 2/28/2025, the facility did not ensure that each resident who needs respiratory care is provided such care consistent with professional standards of practice and the comprehensive person-centered care plan. This was identified for one (Resident #32) of three residents reviewed for Respiratory Care. Specifically, Resident #32 was observed receiving oxygen therapy without a Physician's order. The finding is: The facility's policy titled Oxygen Administration dated February 2024 documented to ensure adequate oxygenation of the body's vital organs. Residents with a clinical diagnosis or clinical indication will receive concentrations of oxygen in doses higher than those found in the atmosphere. Oxygen [therapy] is administered by licensed nursing staff on the written order of the attending Physician. The Physician writes an order for oxygen therapy with a rationale. Resident #32 was admitted with diagnoses including Cerebral Infarction, Heart Failure, and Diabetes Mellitus. The Minimum Data Set assessment dated [DATE] documented the resident had severely impaired cognition and was rarely or never understood. The Minimum Data Set (MDS) assessment documented the resident received oxygen therapy. A review of the medical record indicated there was no care plan developed for the oxygen therapy. A Physician's order dated 1/20/2025 documented to obtain a Pulmonary consultation for Resident #32 related to shortness of breath. The Pulmonary Consultant note dated 1/23/2025 documented that Resident #32 was referred for an evaluation due to shortness of breath and Hypoxia (lack of oxygen to the tissues). The Pulmonologist's recommendations included to monitor the oxygen saturation level while on room air and to provide oxygen therapy as needed to maintain an oxygen saturation level above 92%. A review of Resident #32's medical record revealed there was no evidence of a physician's order for oxygen therapy and to monitor the resident's oxygen saturation level. The Pulmonary Consultant note dated 2/18/2025 documented that at the time of the evaluation, Resident #32 received oxygen therapy at a flow rate of 2 liters per minute via nasal cannula. The Pulmonologist recommended titrating oxygen supplementation as needed to keep the oxygen saturation above 92%. During an observation on 2/24/2025 at 9:56 AM, Resident #32 was lying in bed receiving oxygen therapy via nasal cannula from an oxygen concentrator set to a flow rate of 2 liters per minute. During an observation on 2/27/2025 at 10:00 AM, Resident #32 was lying in bed receiving oxygen therapy via nasal cannula from an oxygen concentrator set to a flow rate of 2 liters per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/28/2025 at 11:00 AM, Resident #32 was lying in bed receiving oxygen therapy via nasal cannula from an oxygen concentrator set to a flow rate of 2 liters per minute. During an interview on 2/28/2025 at 9:35 AM, Licensed Practical Nurse #9 stated all nurses are responsible for oxygen therapy administration. Licensed Practical Nurse #9 stated Resident #32 has been receiving oxygen therapy at 2 liters per minute via nasal cannula since October 2024. Licensed Practical Nurse #9 stated they did not realize there was no physician's order for oxygen therapy and there should have been an order in place. Licensed Practical Nurse #9 stated they check Resident #32's vital signs, including the oxygen saturation level, once a week. During an interview on 2/28/2025 at 9:56 AM, Registered Nurse Manager #1 stated the resident returned from the hospital in October 2024 and has been receiving oxygen therapy at 2 liters per minute via nasal cannula since then. Registered Nurse Manager #1 stated they did not know that there was no physician's order for oxygen therapy. Registered Nurse Manager #1 stated the resident needed oxygen therapy because they (the resident) had shortness of breath. During an interview on 2/28/2025 at 10:44 AM, Physician #1 stated Resident #32 received oxygen therapy at 2 liters per minute since October 2024. Physician #1 stated oxygen therapy administration requires a Physician's order. Physician #1 stated they were unaware there was no physician's order in place. Physician #1 stated they entered the Physician's order on 2/28/2025 after the facility informed them that the resident received oxygen therapy without a physician's order. During an interview on 2/28/2025 at 12:55 AM, the Director of Nursing Services stated they were not aware the resident received oxygen therapy without a physician's order. The Director of Nursing Services stated oxygen therapy administration requires a physician's order. 10 NYCRR 415.12(k)(6)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44925 Based on observation, record review, and interview during the Recertification survey initiated on 2/24/2024 and completed on 2/28/2025, the facility did not ensure the Physician reviewed the resident's total program of care, including medications and treatments, at each visit. This was identified for one (Resident #32) of five residents reviewed for Respiratory care. Specifically, Resident #32 received Oxygen therapy without a physician's evaluation and physician's order. The finding is: The facility's policy titled Oxygen Administration dated February 2024 documented to ensure adequate oxygenation of the body's vital organs. Residents with a clinical diagnosis or clinical indication will receive concentrations of oxygen in doses higher than those found in the atmosphere. Oxygen [therapy] is administered by licensed nursing staff on the written order of the attending Physician. The Physician writes an order for oxygen therapy with a rationale. Resident #32 was admitted with diagnoses including Cerebral Infarction, Heart Failure, and Diabetes Mellitus. The Minimum Data Set assessment dated [DATE] documented the resident had severely impaired cognition and was rarely or never understood. The Minimum Data Set (MDS) assessment documented the resident received oxygen therapy. A review of the medical record indicated there was no care plan developed for the oxygen therapy. A Physician's order dated 1/20/2025 documented to obtain a Pulmonary consultation for Resident #32 related to shortness of breath. The Pulmonary Consultant note dated 1/23/2025 documented that Resident #32 was referred for an evaluation due to shortness of breath and Hypoxia (lack of oxygen to the tissues). The Pulmonologist's recommendations included to monitor the oxygen saturation level while on room air and to provide oxygen therapy as needed to maintain an oxygen saturation level above 92%. A review of Resident #32's medical record revealed there was no evidence of a progress note or a physician's order for the use of oxygen therapy and to monitor the resident's oxygen saturation level. The Pulmonary Consultant note dated 2/18/2025 documented that at the time of the evaluation, Resident #32 received oxygen therapy at a flow rate of 2 liters per minute via nasal cannula. The Pulmonologist recommended titrating oxygen supplementation as needed to keep the oxygen saturation above 92%. A review of Resident #32's medical record revealed there was no evidence of a progress note or a physician's order for the use of oxygen therapy and to monitor the resident's oxygen saturation level. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/24/2025 at 9:56 AM, Resident #32 was lying in bed receiving oxygen therapy via nasal cannula from an oxygen concentrator set to a flow rate of 2 liters per minute. During an observation on 2/27/2025 at 10:00 AM, Resident #32 was lying in bed receiving oxygen therapy via nasal cannula from an oxygen concentrator set to a flow rate of 2 liters per minute. During an observation on 2/28/2025 at 11:00 AM, Resident #32 was lying in bed receiving oxygen therapy via nasal cannula from an oxygen concentrator set to a flow rate of 2 liters per minute. During an interview on 2/28/2025 at 9:56 AM, Registered Nurse Manager #1 stated the resident returned from the hospital in October 2024 and has been receiving oxygen therapy at 2 liters per minute via nasal cannula since then. Registered Nurse Manager #1 stated they did not know that there was no physician's order for oxygen therapy. Registered Nurse Manager #1 stated the resident needed oxygen therapy because they (the resident) had shortness of breath. During an interview on 2/28/2025 at 10:44 AM, Physician #1 stated Resident #32 received oxygen therapy at 2 liters per minute since October 2024. Physician #1 stated oxygen therapy administration requires a Physician's order. Physician #1 stated they were unaware there was no physician's order in place and did not realize there were recommendations provided by the Pulmonologist. Physician #1 stated they entered the Physician's order on 2/28/2025 after the facility informed them that the resident received oxygen therapy without a physician's order. During an interview on 2/28/2025 at 12:55 AM, the Director of Nursing Services stated they were not aware the resident received oxygen therapy without a physician's order. The Director of Nursing Services stated oxygen therapy administration requires a physician's order. 10 NYCRR415.15(b)(1)(i)(ii)

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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** 48827 Based on observations, record review, and interviews during the Recertification Survey initiated on 2/24/2025 and completed on 2/28/2025, the facility did not establish and maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections. This was identified for one (Resident #521) of three residents reviewed for the Infection Control Task, and one (Resident #147) of five residents reviewed for Respiratory Care. Specifically, 1) Resident #521 had a physician's order for Contact Precautions due to Clostridium difficile infection. On 2/25/2025 at 8:09 AM, Certified Nursing Assistant #3 was observed coming out of Resident#521's room carrying two meal trays without wearing any Personal Protective Equipment including a gown or gloves. 2) Specifically, Resident #147 was ventilator dependent and was readmitted to the facility on [DATE] from the hospital with a Multidrug-Resistant Organism (MDRO) Pneumonia infection. On 2/27/2025, Respiratory therapist #1 was observed changing the tracheostomy inner cannula without wearing a face mask or face shield. The findings are: The facility's policy titled Transition Based Isolation last reviewed 9/2024, documented each infectious disease is considered individually so that only those precautions (private rooms, masks, gowns, and gloves) that are indicated to interrupt transmission for that disease is recommended. All isolation procedures will be in accordance with recommendations for isolation precautions as required by the Centers for Disease Control. 1) Resident #521 was admitted with diagnoses that include Enterocolitis (inflammation in both intestines at once) due to Clostridium difficile, End Stage Renal Disease, and Malignant Neuroendocrine Tumors. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, indicating Resident #521 had moderately impaired cognition. The Minimum Data Set documented Resident #521 had a Multidrug-Resistant Organism. A physician's order dated 1/25/2025 documented Contact Precautions (Clostridium difficile) every shift. This order was discontinued on 2/25/2025 at 8:33 AM. The Comprehensive Care Plan for Diagnosis of Colitis with a history of Clostridium difficile dated 1/25/2025 documented interventions that included Contact Isolation and staff to wear gowns and gloves. During an observation on 2/25/2025 at 8:09 AM, a Contact Precaution sign was outside Resident #521's room which documented that everyone must clean their hands before entering the room and after exiting the room. Providers and staff must put on gowns and gloves before entering the room. Certified Nursing Assistant #3 was observed walking out of Resident #521's room carrying two meal trays that were used by Resident #521 and their roommate for their breakfast meal. Certified Nursing Assistant #3 was not wearing any Personal Protective Equipment including a gown or gloves. Certified Nursing Assistant #3 placed the used meal trays on the meal truck with other used meal trays, cleansed their hands with a hand sanitizer, and did not use soap and water. (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 interview on 2/25/2025 at 8:09 AM, Certified Nursing Assistant #3 stated they were told that the resident was no longer on Contact Precautions and the signage should have been taken down. Certified Nursing Assistant #3 stated they were not sure who told them that the resident was no longer on contact precautions. They stated they should have put on Personal Protective Equipment and followed the Contact Precaution signage on the door for Contact Precautions. During an interview on 2/27/2025 at 10:49 AM, the Registered Nurse/Infection Preventionist stated the staff should have followed the Contact Precautions signage and should have put on appropriate Personal Protective Equipment as indicated on the sign. During an interview on 2/28/2025 at 1:32 PM, the Director of Nursing Services stated staff should have followed the Contact Precaution signage and put on appropriate Personal Protective Equipment. 17585 2) The Centers for Disease Control (CDC) Multidrug-Resistant Organisms (MDRO) Management Guidelines dated 3/18/2024 documented to use of masks according to Standard Precautions when performing splash-generating procedures (e.g., wound irrigation, oral suctioning, intubation) and when caring for patients with open tracheostomies and the potential for projectile secretions. Resident #147 was admitted with diagnoses including Multidurg-Resistant Organism (MDRO) Pneumonia. The Minimum Data Set assessment dated [DATE] did not include a Brief Interview for Mental Status because the resident was rarely/never understood. The resident received tracheostomy care and was ventilator-dependent. A Comprehensive Care Plan titled Pseudomonas (bacteria) in the sputum evidenced by positive wound culture effective 1/2/2025 documented the resident had an active infection requiring universal [standard] precautions when providing resident care. Interventions included administering antibiotics as per the physician's orders and maintaining universal precautions when providing resident care. The hospital infectious disease consult dated 2/10/2025 documented the resident was positive for Pseudomonas of the Sputum. The Patient Review instrument (an assessment tool to determine patient placement) dated 2/17/2025 documented the resident required Contact Isolation Precautions secondary to Pseudomonas Multidrug-Resistant Organisms (MDRO) infection. A medical readmission note dated 2/18/2025 documented the resident was seen on telemedicine for readmission medication reconciliation. The patient's chart, discharge papers, and the discharge medication lists were reviewed Ventilator-associated pneumonia. A Physician's order dated 2/18/2025 documented Contact Precautions. A Physician's order dated 2/18/2025 documented a Tracheostomy Tube, Uncuffed; provide tracheal suctioning as needed; tracheostomy tube change every 12 weeks and as needed; change the Ventilator Circuit monthly and as needed; ensure ventilator tubing is off the floor. A medical progress note dated 2/20/2025 documented sputum culture with Pseudomonas. (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 and interview on 2/27/2025 at 2:13 PM, Resident #147 was lying in bed in their room. A sign outside the resident's room documented Contact Precaution: Put on gloves and a gown before entering the room. The Respiratory Therapist #1 was observed wearing a gown and gloves. Respiratory Therapist #1 set up their equipment on the bedside table, then proceeded to suction the resident via tracheostomy tube through a closed suction system. The resident was observed coughing during suctioning. Respiratory Therapist #1 then cleansed the tracheostomy stoma area and applied a clean tracheostomy stoma dressing. Respiratory Therapist #1 performed hand hygiene and donned (put on) new gloves, disconnected the ventilator tubing from the tracheostomy, and removed the old inner cannula from the tracheostomy. Respiratory Therapist #1 then applied a new inner cannula, and re-attached the ventilator tubing. Respiratory Therapist #1 was not wearing a mask or eye protection while the ventilator tubing was disconnected and the tracheostomy inner cannula was being changed. Respiratory Therapist #1 was immediately interviewed and stated that the resident had a closed tracheostomy system connected to the ventilator and therefore they were not required to wear a mask. During an interview on 2/27/2025 at 2:43 PM, the Infection Control Registered Nurse #1 stated they reviewed the resident's Patient Review instrument with the admission nurse and the resident's Physician. The Physician only ordered Contact precautions and under Contact precautions, the Respiratory Therapist is only supposed to wear gloves and a gown. During an interview on 2/28/2025 at 9:51 AM, the Infectious Disease Physician stated the Respiratory Therapist caring for the resident with Multidrug-Resistant Organisms should have worn a mask. The Infectious Disease Physician stated a face shield and a surgical mask should be worn to prevent the spread of the infection while performing procedures that have the potential to generate aerosolized particles. Not wearing a mask or face shield increases the likelihood of the caregiver's exposure to oral secretions and sputum. During an interview on 2/28/2025 at 9:54 AM, the Medical Director stated Respiratory Therapist #1 should have worn a mask and a face shield when changing the tracheostomy inner cannula due to the risk of exposure to the Pseudomonas, Multidrug-Resistant Organisms in the sputum. 10 NYC RR 415.19(a)(1-3)