STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345168	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MacGregor Downs Health Center by Harborview	2910 MacGregor Downs Road Greenville, NC 27834

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 Based on observation and staff and resident interviews, the facility failed to assess the ability of a resident to self-administer medications and vitamins for 1 of 1 resident with medications observed at bedside (Resident #42). Findings included: Resident #42 was admitted to the facility on [DATE]. Her active diagnoses included anemia, heart failure, hypertension, diabetes, and respiratory failure. Review of Resident #42's Minimum Data Set assessment dated [DATE] revealed she was assessed as cognitively intact. Review of Resident #42's electronic health record on 2/10/25 at 1:06 PM revealed there was no physician's order for self-administration of medications and no self-administration of medication assessment. During observation on 2/9/25 at 11:24 AM two medication cups with pills were observed in Resident #42's room on the resident's bedside table. There were no facility staff members in the resident's room. Resident #42 was in bed and the bedside table with the medication placed in front of her. Review of the Medication Administration Record on 2/10/25 at 8:04 AM revealed Resident #42's morning medications were signed as given by Nurse #2 on 2/9/25 were Amiodarone HCl Oral Tablet 200 milligrams (MG), Ascorbic Acid Tablet 250 MG, Citalopram Hydrobromide Oral Tablet 20 MG, Clopidogrel Bisulfate Oral Tablet 75 MG, Cyanocobalamin Tablet 250 micrograms (MCG), Decubi-Vite Oral Capsule (Multiple Vitamins with Minerals) 1 tablet, Ferrous Sulfate Oral Tablet Delayed Release 1 tablet, Potassium Chloride Extended Release 10 milliequivalents (MEQ), Prednisone Oral Tablet 10 MG, Apixaban Oral Tablet 2.5 MG, Carvedilol Oral Tablet 12.5 MG, and Glucosamine-Chondroitin DS Oral Tablet 500-400 MG. During an interview on 2/9/25 at 11:25 AM Resident #42 stated the nurse left the medications for her on the bedside table and had told her one medication cup contained regular meds and the other contained Vitamins but she did not know which medication cup was which. She concluded she had not taken the medications yet because she did not know which was which. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/9/25 at 11:29 AM Nurse #2 stated she did not intentionally leave the medications in Resident #42's room but now that the surveyor was asking, she remembered she did leave them in the room. She stated the medications cups contained Resident #42's morning medications and when she arrived in the room to administer them that morning, she could not recall the exact time, but the breakfast tray was arriving. She helped other staff pull Resident #42 up in bed and then was pulled to another room to assist another resident. She stated she put the medication cups down on Resident #42's bedside table and told the resident she would be right back. She forgot and did not return to administer the morning medications. She stated she was trained to put non-administered medications back in the locked medication cart if leaving a resident's room to assist another resident. She stated the reason she left them in the room was because she thought she was coming right back. She stated the medication cups contained her scheduled morning medications. During an interview on 2/10/25 at 2:26 PM the Director of Nursing stated medication should not be left at the bedside for Resident #42. Nurse #2 should administer the medications and ensure the medications were taken by the resident before leaving the room. If the nurse needed to leave the room prior to the resident taking all medications, the nurse should lock the remaining medications in her cart after identifying the medication cup with the resident's name.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50404 Based on record review, and resident, family and staff interviews, the facility failed to ensure a copy of the resident's advanced directive was included in the resident's record and failed to provide written advance directive information and/or an opportunity to formulate an advance directive (Residents #105 and #114). This was for 2 of 4 residents reviewed for advance directive. The findings included: A review of the facility's policy titled Residents' rights Regarding Treatment and Advance Directives dated 3/1/22 and reviewed/revised on 3/1/24 revealed it is the policy of this facility to support and facilitate a residents' right to formulate an advance directive. On admission the facility will determine if the resident has executed an advance directive, and if not determine whether the resident would like to formulate an advance directive. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. 1. Resident # 105 was admitted to the facility on [DATE]. A review of Resident #105's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact. Resident #105's care plan last revised on 12/3/24 indicated the resident's code status was full code. There was no documentation in the record for education regarding the formulation of advanced directives and /or an opportunity to formulate advanced directives. An interview was held with Social Worker #3 on 2/10/25 at 11:35 AM and she revealed she did not discuss advance directives. She stated the admission nurse or Social Worker # 2 would have been responsible for that task. In an interview with Social Worker #2 on 2/10/25 at 11:45 AM, she stated she had only been employed at the facility for two months and did not have to deal with advance directives. If there was a request for help with advance directives she would help them. She further stated the admission nurse was responsible for advance directives. An interview with Admission Nurse #1 on 2/11/25 at 3:45 PM who admitted Resident #105 revealed if a resident had advance directives in place upon admission, the document was downloaded into the system by the Administrative Ambassador. If a resident did not have advance directives in place she did not initiate a conversation to educate or formulate advance directives. She went on to state she thought the Admissions Director was responsible for that task. An interview with the Admissions Director was conducted on 2/11/25 at 4:00 PM at which time she stated she did not discuss advance directives with families or residents. She indicated that would be the admission nurse's responsibility. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the Administrator and the Director of Nursing on 2/11/25 at 4:10 PM. The DON indicated the social worker assigned to each resident was tasked to speak with and educate the resident and the resident's responsible party about advance directives. 41009 2. Resident #114 was admitted to the facility on [DATE] with a diagnosis of left leg fracture. A review of Resident #114's admission Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired. A review of Resident #114's medical record did not reveal any documentation of a discussion to determine whether or not Resident #114 had formulated any advanced directives such as a living will or a health care power of attorney or would like to formulate one. Additionally, there were no copies of such documents in Resident #114's medical record. On 2/12/25 at 8:33 AM in a telephone interview Resident #114's family member stated she did not recall anyone at the facility having a conversation with her regarding the formulation of advanced directives. She stated Resident #114 had both living will and a health care power of attorney documents. She reported she could not recall anyone from the facility asking her to bring copies of the documents to the facility, and she had not done so. On 2/12/25 at 9:42 AM an interview with Admissions Nurse #2 indicated she did not have conversations with residents or their family regarding advanced directives such as a living will or a heath care power of attorney during her admissions process. She stated she only discussed code status. On 2/12/25 at 9:52 AM an interview with the Admissions Director indicated she spoke with resident's and their family members regarding advanced directives such as living wills or health care powers of attorney during the admissions process and asked them to bring copies of any documents they had already formulated. She stated she did not document these conversations anywhere, and she could not recall whether Resident #114 or his family member reported having a living will or a health care power of attorney to her. The Admissions Director stated she didn't see anything in his medical record. On 2/12/25 at 11:28 AM an interview with Social Worker #2 indicated she did not recall ever having a conversation with Resident #114 or his family member regarding advanced directives such as a living will or a health care power of attorney. She stated typically if a resident had a living will or a health care power of attorney the resident or a family member would bring her a copy. She stated she did not see either of these documents in Resident #114's medical record. On 2/12/25 at 11:33 AM an interview with Social Worker #3 indicated she did not know whether or not Resident #114 had a living will or a health care power of attorney. She stated typically if a resident had either of these documents, they would bring a copy in for the medical record. She reported the only thing with regards to advanced directives she could see in Resident #114's medical record was the desire to be a full code status. Social Worker #3 stated if a resident or a family member brought up the desire to formulate other advanced directives at the care plan meeting, she would have a discussion with them at that time, but Resident #114 had not had a long-term care plan meeting yet. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/25 at 8:09 AM an interview with the Director of Nursing indicated that when a resident was admitted to the facility, the Admissions Director would get any copies of advanced directive paperwork such as a living will or a health care power of attorney a resident had. She reported if someone needed assistance with formulating an advanced directive, the SW would assist with this. On 2/13/25 at 9:44 AM an interview with the Administrator indicated the facility should have a process in place for determining whether a resident had or would like to formulate advanced directives such as a living will or a health care power of attorney.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 Based on record review and staff interviews, the facility failed to provide a CMS-10055 (Centers for Medicare and Medicaid Services) Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF/ABN) for 1 of 3 residents reviewed for beneficiary notices (Resident #89). Findings included: Resident #89 was admitted to the facility on [DATE]. Review of Resident #89's electronic health record revealed Medicare part A services began on 1/6/25. The resident's last covered day of Medicare Part A was 1/19/25. Resident #89 remained in the facility following her discharge from Medicare Part A. There was no evidence a SNF/ABN form was provided to the resident or resident representative. During an interview on 2/11/25 at 11:19 AM Social Worker #3 stated Resident #89's last covered date was 1/19/25 for Medicare part A. A SNF/ABN was missed and not provided to Resident #89 and it should have been. The SNF/ABN was used to provide the resident or representative information regarding what costs they would be responsible to pay out of pocket should they continue the services which were no longer covered by insurance. During an interview on 2/11/25 at 11:45 AM the Administrator stated Resident #89 should have received a SNF/ABN.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009 Based on record review and staff interviews, the facility failed to develop the comprehensive care plan in the area of pain for 1 of 28 residents (Resident #114) whose comprehensive care plans were reviewed. Findings included: Resident #114 was admitted to the facility on [DATE] with a diagnosis of left leg fracture. A review of Resident #114's admission Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired. He had been on a scheduled pain medication regime. He had pain almost constantly. His pain affected his sleep and interfered with his daily activities almost constantly. Resident #114 rated his pain as a 10 on a zero to 10 scale with zero being no pain and 10 being the greatest pain. The Care Area Assessment (CAA) for pain was triggered. A review of Resident #114's comprehensive care plan dated as initiated on 1/27/25 did not reveal a focus area for pain. On 2/11/25 at 10:11 AM in an interview the MDS Director stated Resident #114's comprehensive care plan should have been developed by 1/27/25 based on his comprehensive admission MDS assessment date of 1/14/25. She stated the MDS Coordinator completing Resident #144's comprehensive MDS assessment dated [DATE] would have been responsible for ensuring the CAA for pain which was triggered on the assessment was developed on this comprehensive care plan. On 2/11/25 at 10:20 AM an interview with the MDS Coordinator indicated she completed Resident #114's MDS assessment dated [DATE]. She stated the presence of Resident #114's pain during this assessment was something that triggered the CAA for pain. She went on to say this should have been reflected on Resident #114's comprehensive care plan when it was developed, and it was not. She reported this was an oversight on her part. On 2/13/25 at 8:09 AM an interview with the Director of Nursing indicated Resident #144's pain was something that should have been included on his comprehensive care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009 Based on observations, record review, and staff and physician interviews, the facility failed to follow a physician's order for placement of a lidocaine (topical pain medication) patch on a resident's left hip when the patch was applied to the resident's back. This was for 1 of 2 residents (Resident #114) reviewed for professional standards of practice. Findings included: Resident #114 was admitted to the facility on [DATE] with a diagnosis of left leg fracture. A review of Resident #114's admission Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired. He had been on a scheduled pain medication regime. He had pain almost constantly. His pain affected his sleep and interfered with his daily activities almost constantly. Resident #114 rated his pain as a 10 on a zero to 10 scale with zero being no pain and 10 being the greatest pain. Resident #114's active physician's orders as of 2/10/25 revealed a physician's order dated 1/16/25 for a lidocaine (topical pain medication) 5 percent (%) patch to be applied topically to Resident #114's left hip in the morning and at bedtime for pain. There was no physician's order for a lidocaine patch to be applied to Resident #114's back. Resident #114's February 2025 Medication Administration Record (MAR) revealed documentation indicating Nurse #10 applied a lidocaine 5% patch topically to Resident #114's lower back on at 9:00 AM on 2/10/25. On 2/11/25 at 8:09 AM an observation of bathing activity was conducted for Resident #114 with Nurse Aide #3. During the activity, a topical pain patch was observed on Resident #114's mid-back dated 2/10/25 with the initials that corresponded to Nurse #10. On 2/11/25 at 8:39 AM in an interview Nurse #10 stated she applied a lidocaine 5 % patch topically to Resident #114's back in the morning on 2/10/25. She stated that when she went in to administer Resident #114's medication that morning, he refused for her to put the patch on his left hip and asked her to place the patch on his back, so she had. She reported she should not have applied a lidocaine patch on Resident #114's back without a physician's order to do so. Nurse #10 stated she should have gotten a physician's order first. On 2/11/25 at 8:50 AM an interview with the Director of Nursing indicated Nurse #10 should not have applied a lidocaine patch to Resident #144's back without a physician's order to do so. She stated if Resident #114 had been requesting to have a lidocaine patch for his back, Nurse #10 should have contacted the physician. On 2/11/25 at 11:47 AM in an interview Resident #114's Physician stated Nurse #10 should not have applied a lidocaine patch to a body part she did not have an order for. The Physician stated she was present in the facility on 2/10/25, and Nurse #10 should have spoken to her and gotten an order before she did this. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/24 at 9:44 AM in an interview the Administrator stated Nurse #10 should not have applied a lidocaine patch to Resident #114's back without a physician's order to do so.

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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** 48230 Based on record review, staff, resident and physician interview, the facility failed to clarify orders for blood sugar monitoring and insulin administration for short and long-acting insulins (insulin is a medication injected into the skin to control blood sugar) from the hospital discharge summary for a resident with a diagnosis of diabetes (Resident #81). This was for 1 of 2 residents reviewed for professional standards of practice. The findings included: The hospital discharge summary for Resident #281 dated 2/7/25 stated in part: - Monitor blood sugars closely - Sliding scale insulin (short acting insulin) - Continue Lantus (long-acting insulin) The hospital discharge summary revealed that upon Resident #281's arrival in the emergency department on 1/17/25 he told hospital staff that he had not been taking his diabetic medication for some time as he did not believe it would help him. Resident #281 was admitted to the facility on [DATE] with diagnoses that included Diabetes Mellitus II, osteomyelitis (bone infection) and sepsis (blood infection from osteomyelitis) and surgical removal of last two toes on left foot due to gangrene caused by Diabetes Mellitus II. Review of physician orders for Resident #281 revealed there were no orders for blood sugar monitoring, sliding scale insulin or Lantus insulin. Resident #281's Medication Administration Record (MAR) for February 2025 did not include blood sugar monitoring, Lantus insulin or short-acting insulin. Further review of the MAR revealed that Resident #281 had not received blood sugar monitoring or insulin administration since admission. A review of Resident #281's medical record did not reveal documentation of blood sugar monitoring since admission on 2/7/25. Resident #281's Admission Minimum Data Set (MDS) was not yet available. An interview was conducted on 2/10/25 at 9:04 AM with Resident #281. The resident stated he was diabetic and was admitted to the facility after having two toes removed on his left foot due to diabetes. He further stated he was supposed to be on insulin at home before the operation to remove his toes. Resident #281 revealed he did not believe that insulin or blood sugar monitoring would help him in any way and that was why he had two toes removed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Admissions Nurse #1 on 2/11/25 at 2:25 PM she revealed she was the Nurse that completed the admission orders for Resident #281 on 2/7/25. Admissions Nurse #1 stated she was unaware Resident #281 was to have orders for Diabetes Mellitus II monitoring and management including blood sugar checks, short-acting insulin and long-acting insulin. She further stated the resident was admitted in the evening on a Friday (2/7/25) and she overlooked the text box that gave instructions for blood sugars to be monitored closely and for short-acting and long-acting insulin to be administered, as this was written above the medication orders section in the hospital discharge summary. The nurse added, had she seen these instructions, she would have contacted the on-call physician or Nurse Practitioner for specific orders regarding a schedule for blood sugar monitoring and administration of insulin. Nurse #1 indicated she did call the on-call Nurse Practitioner to sign off on the admission orders. Resident #281's Physician (Medical Director) was interviewed on 2/11/25 at 3:01 PM. She stated she was just made aware Resident #281 needed orders to check his blood sugars and for short acting and Lantus insulin. She further stated she wrote orders for blood sugar checks, short acting insulin and Lantus insulin starting the evening of 2/11/25. She further stated Resident #281 just had his blood sugar checked at 2:55 PM and was within normal limits at 135 milligrams per deciliter. The Physician indicated that Resident #281 could have had adverse effects to an extremely high or extremely low blood sugar while it was not monitored or treated. Some effects included changes in mental status, kidney damage or unconsciousness. Resident #281 had not received oral diabetic medications or insulin prior to the blood sugar check at 2:55 PM. In an interview with the Director of Nursing (DON) on 2/11/25 at 3:10 PM she stated that Admissions Nurse #1 should have read the discharge summary in its entirety. She further stated the admissions order process was for the Admissions Nurse to transcribe the orders from the hospital discharge summary, have a second Nurse review the discharge summary and orders and then have them signed off on by a provider. A review of the orders with the DON during the interview revealed that Admissions Nurse #1 signed off on the orders as both the first and second check. In an interview with the Administrator on 2/11/25 at 3:17 PM he stated he was not aware of the admissions process from the point of the nursing process.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 Based on record review, and resident, staff, and physician interviews, the facility failed to provide care in a safe manner when Resident #42 rolled out of bed during care and sustained a skin tear to the left forearm, skin tear to the right upper arm, and hematoma (bruise) to the left hip and when Resident # 92 was rolled out of bed during care and sustained a right arm skin tear this was for 2 of 6 residents reviewed for accidents. (Resident #42 and Resident #92) Findings included: 1. Resident #42 was admitted to the facility on [DATE]. Her active diagnoses included anemia, heart failure, hypertension, diabetes, and respiratory failure. Review of the care guide posted in Resident #42's closet door dated 1/7/25 revealed she was extensive 1 person assistance with transfers and activities of daily living. Review of Resident #42's Minimum Data Set assessment dated [DATE] revealed she was assessed as cognitively intact. She required partial/moderate assistance with the ability to roll from lying on back to left and right side, and returning to lying on back on the bed. Resident #42 was on blood thinner medication. Review of Resident #42's care plan dated 1/9/25 revealed Resident #42 was care planned to be at risk for falls related to deconditioning, back pain, history of falls, impaired balance, gait, and mobility. The interventions included to anticipate and meet the resident's needs, encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. She was care planned to require assistance by staff to turn and reposition in bed as necessary. Review of a progress note dated 1/13/25 noted as a fall note written by Nurse #1 revealed Resident #42 was being changed by the Nurse Aide #2 and slid to the floor. Upon assessment, Resident #42 had a skin tear on her right upper arm and a small skin tear on her left forearm. She also had a bruise on her left hip on the backside that was blackish blue. She was transported to the emergency department. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/10/25 at 3:06 PM Nurse Aide #2 stated she was changing Resident #42 and standing on the side of the bed towards the door changing her brief. She unstrapped the brief and then went to the window side and using the draw sheet, pulled towards herself to turn the resident to face the door. The resident kept rolling which was not something she normally did and her bottom half slid off the side of the bed. When she saw this, she lowered the bed and the resident slid down to a sitting position on the floor with her back against the bed. She stated the resident did not hit the ground hard as she had been able to lower the bed as she was sliding out of it. Her skin would easily bruise and bleed and she was on a blood thinner. She immediately got Nurse #1 and the nurse assessed the resident and it was decided to send the resident to the hospital. She stated she stayed with Resident #42 until the ambulance came to the facility to take her to the hospital. She stated she had been trained when turning a resident to turn them towards herself instead of facing away from herself. She stated she did not know why she turned the resident away from herself that day. She concluded after the resident left in the ambulance, Nurse #1 reeducated her in regards to turning residents towards herself so that her body would be in front of the resident and prevent the resident from continuing to roll. During an interview on 2/10/25 at 11:33 AM Nurse #1 stated she usually worked with Resident #42 and knew her well. She required limited assistance with dressing and one person assistance with turning and repositioning as well as transfers. Nurse #1 stated Resident #42 was at this functioning level since she started working at the facility the beginning of November 2024. She stated Nurse Aide #2 was trying to change Resident #42's brief and instead of rolling the resident towards herself she rolled the resident in the opposite way (the other side of the bed from where the nurse aide was standing) and Resident #42 continued to roll, and her legs fell off the side of the bed. This caused Resident #42 to begin to slide off the bed. Nurse Aide #2 started lowering the bed as the resident slid to the floor. The nurse aide then came and got the nurse who did an assessment. She saw that Resident #42's right leg was bent oddly, and she had two skin tears. One skin tear on each forearm. It wasn't fast or heavy bleeding but it was enough they had to hold pressure to her arms. She also had a bruise on her left hip that was blackish blue. From there she got Admission Nurse #1 (who was the unit manager at the time) and they got an order to send the resident to the hospital. Resident #42 did not want to go but the Responsible Party wanted her to go to the hospital and because the Responsible Party wanted her to go to the hospital she agreed to go. The resident was sent directly to the hospital, and she did not provide the resident with any pain medication at that time as Resident #42 had indicated to her she did not want pain medication. The resident stated she had pain but kept stating she was fine and did not want to go to the hospital until the nurse informed the resident that her Responsible Party wanted her to go to the hospital. She stated she then reeducated Nurse Aide #2 to ensure she turned residents towards herself and not away from herself when providing activities of daily living care. Review of the hospital discharge summary dated 1/30/25 revealed Resident #42 had sustained an accidental fall which resulted in a left hip hematoma. A CT (Computed Tomography) scan of the head and a CT scan of the cervical spine for Resident #42 were negative for acute intracranial abnormality. A CT scan of the abdomen and pelvis were noted to have hematoma within the subcutaneous tissues of the left lateral lower abdominal wall and hip. Resident #42 was hospitalized for unrelated health concerns. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/9/25 at 11:44 AM Resident #42 stated two weeks ago she fell in her room but did not really remember the details. Resident #42 stated her left hip had pain, and she sustained a large bruise as a result of the fall. Resident #42 stated a nurse aide was providing care to her at the time but did not remember the nurse aide's name or the time of day. Resident #42 stated the nurse aide placed her on the edge of the bed, and she fell to the floor. The nurse aide was upset and got a nurse. The nurse told the resident she should go to the hospital. Resident #42 stated she told the staff she was fine and did not need any pain medications and just needed to be put back in bed, but they worried her Responsible Party, and he wanted her to go to the hospital. She stated she was in pain following her bottom hitting the floor and estimated the pain was an 8 out of 10 and did not remember if she got pain medication. The pain did not last long and got much better before she arrived at the hospital. She could not remember what all happened at the hospital or how long she was there. She stated it was an accident and did not have anything else to add about the fall. During an interview on 2/12/25 at 7:53 AM Admission Nurse #1 stated she was the unit manager at the time of Resident #42's fall. Staff yelled for help and when she arrived, Nurse #1 was concerned the resident might have broken her hip, but Resident #42 kept stating she was okay, did not want to go to the hospital, and was not in pain. The physician was called, and the Responsible Party was called, and they were trying to convince the resident to go to the hospital, which she did finally agree to when they told her that her Responsible Party wanted her to go as well as the physician. Because the resident was stating she did not have pain and just asking staff to put her back in bed, they did not provide any pain medication at that time. Emergency Medical Services arrived quickly, and they took her out to the hospital, and she did not have any fractures, just a large bruise on her left hip and skin tear to both arms. She stated she then spoke to Nurse Aide #2 separately and re-educated the nurse aide to always turn residents towards herself instead of away from herself to prevent accidents like this. During an interview on 2/11/25 at 11:01 AM the Physician stated it sounded like Nurse Aide #2 thought she was providing care correctly and then was educated later after the incident by nursing how to appropriately turn residents. The nurse aide should have turned the resident towards herself in order for the nurse aide's body to prevent the resident from continuing to roll off the bed so the reeducation was appropriate. She stated the outcome for Resident #42 was a skin tear to each forearm and a hematoma to the left hip. She stated the resident did not hit her head so she felt there were no other outcomes that could have resulted from this incident for the resident or other residents. During an interview on 2/10/25 at 3:28 PM the Director of Nursing stated a resident should never sustain a fall during care and she was notified when Resident #42 sustained her fall. She stated Nurse Aide #2 should have turned the resident towards herself in order for her body to prevent the resident from rolling further. She stated this was how staff were trained to turn and reposition residents. During a follow up interview on 2/13/24 at 8:10 AM the Director of Nursing stated upon review of the documentation regarding Resident #42's fall, the facility did not complete 100% in-services of all nurses and nurse aides in the facility following the fall. She further stated they reviewed three residents following the incident and did not complete a 100% audit of all residents who could have been affected. 41009 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #92 was admitted to the facility on [DATE] with a diagnosis of heart failure. A review of Resident #92's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact. She had functional impairment in range of motion on one side of her upper extremities and both sides of her lower extremities. She required substantial assistance to roll from left to right in bed. She was always incontinent of bladder. She had no falls since her prior assessment. A review of a nursing progress note for Resident #92 dated 12/5/24 at 8:11 PM written by Nurse #1 indicated Resident #92 experienced a fall from bed at 6:00 PM that day. Nurse Aide (NA) #1 was present during the fall and provided Nurse #1 with a full statement of the incident. NA #1 had been attempting to change Resident #92's bed sheets, turned Resident #92 away from herself, pulled on the bed sheets, and Resident #92 fell off the bed onto her right side. Resident #92 had not hit her head. A full body assessment and vital signs were done. Resident #92 any pain. Resident #92 had a right arm skin tear which was cleaned, and a dry dressing was applied. Her family member and physician were notified. A review of a written statement by Nurse #1 dated 12/5/24 revealed NA #1 had been educated on how to change a resident with one assist. NA #1 was instructed that when changing a resident with one assist, she should turn the resident towards herself and not away from herself. When using a turn sheet, she should be mindful of how light or heavy the resident was and how fast or slow she was pulling the sheet with consideration to where the resident's body was positioned in bed. On 2/12/25 at 3:43 PM an interview with NA #1 indicated she recalled Resident #92's fall on 12/5/24. She stated when she went into Resident #92's room that day, Resident #92's sheets had been wet. She went on to say Resident #92 had been positioned more toward the right side of her bed and when she pulled on the draw sheet to bring Resident #92 closer to herself to turn Resident #92, instead of coming towards her, Resident #92 had rolled off the right side of her bed. She reported Resident #92's bed had been approximately 3 feet from the floor at the time, and Resident #92's upper body had gone off the bed first followed by Resident #92's legs. She stated Resident #92 had not said anything, and she could see that Resident #92 did not hit her head during the fall. NA #1 went on to say she immediately called for Nurse #1 who came to assess Resident #92. She stated although Resident #92 needed only one person to assist with bed mobility, she thought because her bed had been wet the use of the draw sheet had not gone as planned. She reported she had received education after the incident, and in the future would get another person to assist her if a resident's bed was wet. On 2/12/25 at 8:02 AM an interview with Nurse #1 indicated she recalled Resident #92's fall on 12/5/24. She stated when NA #1 notified her she immediately went to assess Resident #92. She reported Resident #92's bed had been positioned approximately 2 feet from the floor and Resident #92 had been lying on the floor beside her bed on her right side. Nurse #1 went on to say she completed a full body assessment of Resident #92 and took her vital signs. She stated Resident #92 had denied any pain, denied hitting her head during the incident and had not seemed upset at the time but was just asking them to get her up. She reported Resident #92 had a skin tear to her right arm which she cleaned and dressed. She went on to say she had notified Resident #92's family member and physician of the fall, and after getting a full statement of the event from NA #1, had notified Admission Nurse #1 who had been her supervisor at the time. Nurse #1 stated she provided immediate education to NA #1 after the incident that NA #1 should always roll residents towards herself when turning them in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order for Resident #92 dated 12/6/24 indicated to clean her right arm skin tear with normal saline and apply a non-adherent gauze dressing every Monday and Friday for skin tear. On 2/12/25 at 7:56 AM an interview with Resident #92 indicated she did not recall ever having fallen from bed during care. She stated she had no concerns with the way NAs provided care to her, and she always felt safe during care. On 2/12/25 at 8:15 AM an interview with Admissions Nurse #1 indicated she did not think she had been present in the facility when Nurse #1 notified her of Resident #92's fall on 12/5/24, and after Nurse #1 notified her by telephone, she notified the Director of Nursing (DON). On 2/12/25 at 8:22 AM an interview with the DON indicated she had been notified of the circumstances of Resident #92's fall on 12/5/24 and immediate education had been provided to NA #1 regarding always turning residents towards herself when turning them in bed. She went on to say she thought an in-service had also been provided to all staff regarding this after the incident. On 2/13/25 at 8:09 AM a follow-up interview with the DON indicated 100 percent staff education had not been completed after Resident #92's fall on 12/5/24. On 2/12/25 at 12:28 PM a telephone interview with Resident #92's Physician indicated Resident #92 had not experienced any major injury as a result of the fall that occurred on 12/5/24. She reported Resident #92 would have been at risk for any injury that could occur as a result of a fall. She stated a fall from bed would not be an anticipated outcome during the provision of care and it must have been a frightening experience for both Resident #92 and NA #1. On 2/13/25 at 9:44 AM an interview with the Administrator indicated Resident #92 should not have sustained a fall during the provision of care. On 2/12/25 a review of an in-service training record dated 12/11/24 provided by the Staff Development Coordinator (SDC) revealed the attached procedure titled: Turning a Resident on His/her Side Away From You which included in part the following: Steps in the Procedure: 5. Slide both your arms under the resident's back to his/her far shoulder. 6. Slide the resident's shoulders towards you on your arms. 7. Slide both your arms (as far as you can) under the resident's buttocks. 8. Slide the resident's buttocks towards you. 9. Slide both arms under the resident's feet and ankles. 10. Slide the resident's feet towards you. On 2/12/25 at 10:44 in an interview the SDC stated she provided an in-service training on the proper procedure for turning a resident on their side away from you in bed to nurses and nurse aides on 12/11/24 in response to Resident #92's fall from bed during care on 12/5/24. She reported that while the in-service did not specifically address the use of a draw sheet, it was standard practice to use a draw sheet when repositioning residents.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009 Based on observations, record review, and staff and family interviews, the facility failed to attempt alternatives to bed rail use and document how these alternatives failed to meet the resident's needs prior to the installation of bed rails. This was for 1 of 6 residents (Resident #114) reviewed for accidents. Findings included: Resident #114 was admitted to the facility on [DATE] with a diagnosis of left leg fracture. A review of Resident #114's medical record revealed an informed consent for the use of bed rails dated 1/7/25 that indicated the risks versus the benefits of bed rail use. This was signed by Resident #114's family member indicating she consented to the use of bed rails for Resident #114. A review of Resident #114's nursing admission assessment dated [DATE] at 4:51 PM completed by Admissions Nurse #2 revealed Resident #114 would have quarter (1/4) length rails on his bed to assist with bed mobility and positioning and to provide a handhold area for support by staff. Resident #114's family member requested to keep side rails on the bed for assistance with positioning and mobility. A review of a side rail/entrapment risk evaluation for Resident #114 dated 1/7/25 at 5:26 PM completed by Admissions Nurse #2 revealed Resident #114 wanted side rails in place and used them for positioning and mobility. The side rails did not inhibit Resident #114's mobility or freedom and were not a restraint. He would have 1/4 length rails on both sides of his bed. The entrapment risk section of the evaluation indicated because Resident #114 had dementia, was able to notify staff of his needs, and had trouble sleeping at night that alternatives to bed rail use should be considered. A review of Resident #114's medical record did not reveal a physician's order for bed rails or any documentation that alternatives to bed rail use were attempted. A review of Resident #114's admission Minimum Data Set (MDS) assessment dated [DATE] revealed he was severely cognitively impaired. He had no impairment in range of motion of his upper or lower extremities. He required moderate assistance (helper does less than half the effort) to roll from left to right in bed, go from sitting on the side of the bed to lying in bed, and to go from lying on the bed to sitting on the side of the bed. He required maximal assistance (helper does more than half the effort) to safely come to a standing position from sitting on the side of the bed. He did not walk. He did not use restraints. On 2/9/25 at 2:09 PM Resident #114 was observed his room. He had 1/4 length bed rails in the raised position on both the left and right side of his bed. On 2/11/25 at 8:01 AM Resident #114 was observed in bed. He had 1/4 length bed rails in the raised position on both the left and right side of his bed. He did not indicate he knew what the bed rails were for. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/25 at 4:27 PM an interview with Resident #114's family member indicated she had signed a consent form for bed rail use when Resident #114 was admitted to the facility. She stated she felt he could use these for help with repositioning. She reported she did not recall anyone ever discussing alternatives to bed rail use with her. On 2/12/25 at 9:42 AM an interview with Admissions Nurse #2 indicated she did not ever discuss or attempt any alternatives to bed rail use with residents or their family. She stated she just explained what they were and what they were for. She reported bed rails were already on most of the beds, and if a resident or family member didn't want them, they could be taken off. On 2/12/25 at 1:15 PM an interview with the Director of Nursing indicated she was not aware of any alternatives to bed rail use used by the facility. On 2/13/25 at 9:44 AM an interview with the Administrator indicated he did not know what alternatives to bed rails were attempted prior to their use. He stated he would need to discuss that with the therapy team.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48230 Based on record review, staff and resident interviews the facility failed to assess for food preferences for 1 of 1 resident reviewed for food preferences (Resident #280). Findings included: Resident #280 was admitted to the facility on [DATE]. Resident #280's 5-day Minimum Data Set (MDS) dated [DATE] indicated the resident was moderately cognitively impaired. An interview with Resident #280 was conducted on 2/9/25 at 12:41 PM. Resident #280 stated she wished the kitchen would stop sending pork products on her tray because she doesn't like pork. She further stated no one had asked her about her food preferences. An interview was conducted on 2/10/25 at 11:18 AM with the Dietary Manager. The Dietary Manager stated food preference assessments were conducted upon admission. A record review by the Dietary Manager was observed at this time that revealed no food preferences had been documented in the computer for Resident #280 and the Dietary Manager was not able to locate the paper assessment for the resident's food preferences. She stated that up until two weeks ago she had an assistant that completed the resident food preferences assessments. An interview was conducted on 2/10/25 at 11:43 AM with the Administrator. The Administrator stated he expected the Kitchen Manager to ensure newly admitted residents are assessed for food preferences upon admission.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41009 Based on observations and staff interviews, the facility failed to store a sugar scoop in a manner that prevented the potential for cross contamination by storing the scoop in the bulk sugar bin with the scoop handle touching the sugar. This was for 1 of 3 pantry's observed. This had the potential to affect food served to residents. Findings included: On 2/11/25 at 4:05 PM an observation of the bulk sugar bin in Hall 2 pantry revealed the sugar scoop was stored directly in the bulk sugar bin with the handle of the scoop in contact with the sugar. In an interview with Dietary Aide #1 at that time she stated she was assigned to the Hall 2 pantry that day. She reported that when she had gone on her break a little after 3:00 PM that day the scoop had not been in the sugar. She stated the sugar scoop should always be stored separately and not in contact with the sugar in the bin for sanitary reasons to prevent the potential for cross contamination. She reported this had probably been done by [NAME] #1. On 2/11/25 at 4:13 PM an interview with the Dietary Manager indicated a scoop should never be stored directly in the bulk sugar bin. She reported this was to prevent the potential cross contamination of the sugar by the scoop. In an interview on 2/11/25 at 4:15 PM [NAME] #1 stated he recently used the sugar from the bulk sugar bin in Hall 2 pantry to make sweet tea for the resident's supper meal. He reported he knew that after using the scoop it should not be stored directly in the sugar to prevent cross contamination of the sugar by the scoop. He stated he accidentally left the scoop in the sugar after he used it. On 2/13/25 at 9:44 AM an interview with the Administrator indicated a scoop should never be stored directly in the bulk sugar bin after it was used. He stated [NAME] #1 knew better than to do this.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	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** 50404 Based on record review and staff interviews, the facility failed to have a complete and accurate Medication Administration Record (MAR) for 1 of 2 residents who received enteral formula (a method of providing nutrition directly into the gastrointestinal tract through a tube) who were reviewed for medical record accuracy (Resident #333). Findings included: Resident #333 was admitted to the facility on [DATE]. Resident #333 Physician's orders included an order dated 11/12/24 for enteral formula Osmolite 1.5, 237 milliliters (ml) to be administered every 6 hours. In a telephone interview with Nurse #4 on 2/11/24 at 8:20 AM she revealed when she started to pour the enteral formula into the tube Resident #333 stated he did not want the formula, she then stopped pouring the enteral formula. She went on to say Resident #333 had not refused his enteral formula to her in times past. Attempts made to reach Nurse #4 for further investigation were not successful. Review of the MAR for 11/27/24 revealed the midnight dose of enteral formula was given as prescribed by Nurse #4. An interview with Nurse #6 was held on 2/11/24 at 12:30 PM at which time she revealed that if a resident refused an enteral formula, she would document the refusal on the MAR as refused. An interview with Nurse #8 was held on 2/11/25, she revealed if a resident refused an enteral formula after she started pouring, she would stop and document on the MAR the resident had refused. In an interview with the Director of Nursing on 2/12/25 at 9:40 AM, she revealed if a resident refused the enteral formula after the start of pouring the enteral formula she would mark refused on the MAR. An interview with the Administrator was held on 2/13/25 at 9:30 AM, he stated the staff should document what happened. He would expect the documentation would state the administration of the enteral formula was incomplete and the resident refused.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50404 Based on observations, record reviews and staff interviews, the facility failed to implement their infection control policies and procedures when Housekeeper #1 failed to wear an isolation gown while cleaning the room of two residents on droplet contact precautions and the Director of Nursing (DON) failed to wear personal protective equipment (PPE) before entering the room of a resident on droplet contact precautions. In addition, Nurse #3 and the Administrative Ambassador failed to wear PPE and perform hand hygiene before entering the room of two residents on droplet contact precautions and Nurse #1 failed to perform hand hygiene before putting on clean gloves and after removing soiled gloves. This deficient practice occurred for 5 of 24 staff (Housekeeper #1, Administrative Ambassador, Director or Nursing, Nurse #3 and Nurse #1) observed for infection control practices. The findings included: 1. The facility policy implemented on 3/1/22 and reviewed/revised on 7/1/24 titled Transmission-Based (Isolation) Precautions read in part It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission. Droplet precautions refer to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. During continuous hall observation on 2/9/25 at 12:15 PM it was observed that a sign was posted on the door to room [ROOM NUMBER] in which Residents #16 and #122 were residing. Both residents had been diagnosed with Influenza A and were on droplet precautions for infection control. The signage stated in part: Droplet Contact Precautions, everyone must 1. Clean hands before entering and when leaving, 2. Wear a gown when entering the room and remove before leaving, 3. Wear a surgical/procedure mask when entering, 4. Wear gloves when entering. Housekeeper #1 was observed wearing only gloves and a surgical mask while wet mopping the floor. In an interview with Housekeeper #1 on 2/9/25 at 12:30 PM he revealed he should have worn a gown into the room, he went on to say he didn't realize the sign on the door showed he needed to wear an isolation gown. An interview was conducted on 2/10/25 at 1:50 PM with the Director of Facility Services. He stated his expectation would have been that his staff wear gowns, masks and gloves when a droplet contact precaution sign is posted on the door. An interview with the Director of Nursing (DON) was held on 2/10/25 at 2:15 PM. The DON stated she revealed her expectation would have been the housekeepers wear a gown, mask, and gloves when working in a droplet precaution room. In an interview with the Administrator on 2/11/25 at 11:58 AM, he stated there had been extensive training regarding precautions, there were signs on the doors that told the staff what PPE they should wear. The staff should wear gowns, gloves, and masks when entering a droplet precaution room as the residents may cough or sneeze and spread infection. 37468 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #57 active diagnoses included influenza. Review of the signage on the door to Resident #57's room read in part, Droplet Contact Precautions. Everyone must: Clean hands before entering and when leaving room. Wear a gown when entering the room and remove before leaving. Wear surgical/procedure mask when entering the room. Remove immediately before leaving room. Wear gloves when entering room. Perform hand hygiene after removing gloves. During observation on 2/9/25 at 10:56 AM the Director of Nursing entered Resident #57's room with no gown or gloves and a surgical/procedure mask, touched the privacy curtain while speaking with Resident #57, washed her hands, and left the room. During an interview on 2/9/25 at 10:57 AM the Director of Nursing, upon looking at the signage on the door, stated she thought it was enhanced barrier precautions room instead of droplet precautions room and she should have put on a gown and gloves prior to entering the room. During an interview on 2/9/25 at 11:03 AM the Administrator stated infection prevention protocols must be followed at all times. 48230 3. During an observation on 2/9/25 at 12:50 PM Nurse #3 and the Administrative Ambassador entered the room of Residents #286 and Resident #287 (room [ROOM NUMBER]). Both residents had been diagnosed with Influenza A and were on droplet precautions for infection control. There were two signs on the door entitled droplet precautions describing what personal protective equipment (PPE) must be worn if entering the room. The required PPE was a gown, gloves and mask in addition to performing hand hygiene before donning PPE. Both Nurse #3 and the Administrative Ambassador walked into the room to investigate a beeping noise without performing hand hygiene or donning the required PPE. In an interview with Nurse #3 on 2/9/25 at 12:54 PM she stated she was worried the beeping noise was an oxygen concentrator and didn't think about donning PPE or performing hand hygiene before entering the room. Nurse #3 further stated she should have performed hand hygiene and donned the proper PPE to enter the room as both residents tested positive for influenza A and were on droplet precautions to prevent the spread of virus. In an interview with the Administrative Ambassador on 2/9/25 at 12:56 PM he stated he was aware of the droplet precautions signage and policy and he should have stopped to don PPE before entering the room. The Director of Nursing (DON) stated in an interview on 2/10/25 at 2:53 PM that all staff were trained on infection control practices such as donning PPE before entering a room with droplet precaution signage. An interview with the Administrator was conducted on 2/11/25 at 11:58 AM. He stated all staff were provided with education on infection prevention and control practices upon hire. He further stated all residents on droplet precautions have a sign attached to their door so staff can easily know what precautions are required and for which tasks. 4. A review of the facility policy titled Hand Hygiene dated 7/1/2023 stated in part: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 6. (a.) the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning (putting on) gloves, and immediately after removing gloves. An observation of a blood glucose check was conducted on 2/11/25 at 9:49 AM. During the observation, Nurse #1 failed to perform hand hygiene before putting on gloves. She carried the gloves into the resident's room with her. Nurse #1 set down the blood glucose monitoring supplies and subsequently dropped one of the gloves on the floor at the resident's bedside. The Nurse then picked up the dropped glove and put it on, put on the other glove and proceeded to check the residents blood sugar. Nurse #1 then failed to perform hand hygiene after removing the gloves and returning to her medication cart where she opened the cart and proceeded to begin pouring medications for the next resident. During an interview, Nurse #1 stated she should have performed hand hygiene before putting on gloves and after taking them off. She further stated using the glove she dropped was a breach in infection control as the floor is considered dirty and it should not have been used on the resident. Nurse #1 indicated she was aware hand hygiene should be performed before donning and after doffing gloves. Nurse #1 indicated she had been educated about infection control upon hire. In an interview on 2/11/25 at 9:59 AM the Director of Nursing (DON) stated hand hygiene such as using hand sanitizer or washing with soap and water should be performed before putting on gloves and after removing them. She further stated anything dropped on the floor is considered contaminated and should be thrown away instead of being used on a resident. This is to avoid introducing infection to the resident. The DON indicated all staff were trained in infection control procedures. An interview with the Administrator was conducted on 2/11/25 at 11:58 AM. He stated all staff were provided with education on infection prevention and control practices upon hire. He further stated that hand hygiene is the frontline defense against the spread of infection and should be performed both before putting on gloves and after removing them. In an interview with the Regional Director of Operations on 2/13/25 at 9:02 AM she revealed that the facility was unable to find documentation that Nurse #1 was educated on infection control at any time since hired on 10/15/24.