STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365410	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfair Village Nursing Care Center	3000 Bethel Rd Columbus, OH 43230

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure Resident #11 was offered activities and had a detailed activities assessment and care plan. This affected one resident (#11) of one resident reviewed for activities. The facility census was 82.Findings include: Review of Resident #11's medical record revealed an admission date of 11/01/25 with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia, chronic heart failure, type two diabetes mellitus, and other frontotemporal neurocognitive disorder.Review of Resident #11's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was rarely or never understood. Review of Resident #11's plan of care dated 11/03/25 revealed the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs. Interventions included introducing residents to residents with similar background and interests, inviting to scheduled activities, and providing a program of activities of interest. Review of Resident #11's activity evaluation dated 11/03/25 revealed the resident was catholic and actively participated in his religion. Activities that were very important to him included pets and sports. Activities that were somewhat important to him included board games, community outings, current events, cultural events, educational programs, family or friend visits, group discussion, movies, music, television. and radio. He was interested in activities and was cooperative and cheerful.Observation on 04/14/26 at 7:47 A.M. revealed Resident #11 was awake, his room was dark and he had no entertainment. Observation at 1:14 P.M. revealed Resident #11 was watching television.Observation on 04/15/26 at 7:54 A.M. 9:50 A.M. and 1:10 P.M. revealed Resident #11 in a dark room with television on.Interview on 04/15/26 at 9:51 A.M. with Activities Assistant #134 revealed Resident #11 refused a lot of activities, he did not like to do what they offered him. Activities Assistant #134 verified the activities he was offered and refused were not documented, and there was limited activity documentation.Interview on 04/16/26 at 11:19 A.M. with Activities Assistant #133 and Activities Assistant #134 revealed they knew he liked trivia. They were unable to access the activity assessment and care plan. They were unsure of his specific preferences like what television and music he enjoyed. They were unaware he was catholic, Activities Assistant #133 reported they have people come in to visit the Catholics that resided in the facility and could add him to the list.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview and facility policy review, the facility failed to notify the Psychiatric Certified Nurse Practitioner when a resident had behavior and mood changes. This afffected one resident (#41) of two residents reviewed for behavioral, mental and emotional health care and services. The census was 82. Findings include:Review of the medical record Resident #41 revealed an admission date of 03/09/24 with a Brief Interview ofr Mental Status (BIMS) score of 15 indicating no cognitive deficits. His diagnoses included Arnold Chiari Syndrome, hydrocephalus, mood disorder, depression, benign neoplasm of the brain and adult failure to thrive.Review of Resident #41's Psychiatric Certified Nurse Practitioner #271 psychiatric note on 01/30/26 revealed she indicated nursing follow up with the provider in 2-4 weeks, unless acute issue or concerns presents .Review of Resident # 41's progress notes dated 02/03/26 at 4:05 P.M. the Interdisciplinary Team recorded Resident #16 had escalating changes in mental status, behaviors, multiple recent hospitalizations related to increased confusion with significant decline in baseline, including not taking his medications, refusal of meals despite repeated encouragement, and active hallucinations and paranoid thought processes. The facility's Medical Director was notified and by telephone indicated Resident #16 should be sent to hospital via Application for an Emergency Hospitalization. The local police were contacted and arrived at the facility at 5:42 P.M. and denied the notification of the Application for an Emergency Hospitalization form and asked the resident if he would like to be escorted to the hospital for care. Resident #41 agreed and was transported to the hospital.Review of his care plan last updated on 02/23/26 revealed he was independent for activities of daily living and walks around the facility and in the community independently. He received psychological services with contracted counseling group including a Psychiatric Certified Nurse Practitioner # 271 every two weeks and a nurse visit every other week.Interview with Resident #41 on 04/13/26 at 2:00 P.M. confirmed Previous Director of Nursing # 267 came to his room on 02/03/26 in the afternoon and told him that they were pink slipping him that afternoon, because he needed to go to the hospital. He was unaware that he had a change in condition or was displaying different behaviors. When the police arrived, they spoke to him and he agreed to go to the hospital for care.Interview on 04/14/26 at 1:00 P.M. with the previous Director of Nursing #267 confirmed no one notified Resident #41's Psychiatric Certified Nurse Practitioner # 271 of behavior or mood changes prior to completing the Application for an Emergency Hospitalization form and notifying the police. Interview on 04/14/26 at 1:30 P.M. with Nursing Supervisor # 262 confirmed she was working with the previous Director of Nursing # 267 and Regional Representative # 400 when the pink slip was being completed, at no time did anyone notify Resident #41 Psychiatric Certified Nurse Practitioner # 271 of behavior or mood changes.Interview with the Psychiatric Certified Nurse Practitioner #271 on 04/20/26 at 9:10 A.M. confirmed she saw Resident #41 on 01/30/26 and at that time she was aware of the behaviors he was exhibiting , however, did not believe he needed to be sent to the hospital. She confirmed she was not notified of any behaviors or change in condition for Resident #41 or that he was sent to the hospital on [DATE] . She found out about his hospital admission when she saw him on 02/27/26.Review of the facility's , Changes in Resident's Condition or Status, dated 11/26/2018 the facility must notify the resident, his/her primary care provider, and resident/resident representative of changes in the resident's condition or status.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to timely address Resident #79's Urinary Tract Infection (UTI). This affected one resident (#79) of two residents reviewed for UTI. The facility census was 82.Findings include:Review of Resident #79's medical record revealed an admission date of 12/10/25 with diagnoses including chronic kidney disease, osteoarthritis, cognitive communication deficit, adult failure to thrive, delirium, and vascular dementia. Review of Resident #79's progress note dated 03/03/26 at 8:29 P.M. revealed she complained of pain while urinating. The on-call nurse practitioner was notified and ordered urine to be collected for analysis.Review of Resident #79's physician order dated 03/03/26 revealed an order to collect urine for a urinary analysis with culture and sensitivity related to complaints of pain while urinating.Review of Resident #79's progress note dated 03/04/26 revealed Certified Nurse Practitioner (CNP) #266 saw the resident due to dysuria. A urinary analysis was pending. The resident appeared to have recurrent UTI's and she would consider adding cranberry.Review of Resident #79's progress note dated 03/04/26 at 9:45 A.M. revealed the resident's urine had been picked up by the lab.Review of Resident #79's urinary analysis dated 03/04/26 revealed her urine had been collected and the results were pending.Review of Resident #79's progress notes from 03/04/26 to 03/15/26 revealed the resident's potential UTI, urinary symptoms, and laboratory results were not addressed.Review of Resident #79's urinary analysis revealed her urine was collected on 03/09/26 and the results were reported on 03/13/26. The culture identified bacteria present in her urine that was susceptible to certain antibiotics.Review of Resident #79's progress note dated 03/16/26 at 2:52P.M. revealed CNP #266 followed up on the urine culture with positive reports and dysuria. The resident had complained of dysuria starting 03/03/26. The CNP ordered antibiotics following the results of the culture and sensitivity.Review of Resident #79's physician order dated 03/17/26 to 03/20/26 revealed an order for Cefitraxone sodium injection solution one gram (gm) injected intramuscularly one time a day for three days for a UTI.Review of Resident #79's physician order dated 03/17/26 revealed an order for Cranberry tablet 450 mg one time a day for recurrent UTI's.Review of Resident #79's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition. She was frequently incontinent of bowel and bladder. Review of Resident #79's plan of care on 04/15/26 revealed it did not address her risk for UTI's or her recurrent UTI's.Interview on 04/15/26 at 9:40 A.M. with the Director of Nursing (DON) revealed the laboratory threw out the urine that had been collected on 03/04/26 so it had to be redone. She verified there was no documentation related to this, when they were notified of this, and if the resident continued to have symptoms.Interview on 04/15/26 at 10:30 A.M. with CNP #266 revealed they had multiple issues with the current lab they were using. Often the facility received a report back from the lab saying they would not run the sample, this is what happened in this case. Resident #79 continued to have symptoms on and off, so they collected her urine again. On 03/13/26 the lab said they were not going to culture it, CNP #266 stated she requested a culture. The culture came in on 03/16/26 which is when she ordered antibiotics.Interview on 04/15/26 at 3:14 P.M. with Regional MDS #273 verified the residents recurrent UTI's should have been addressed in the plan of care.The facility did not have policies related to UTI.This violation represents noncompliance investigated under complaint 2746176.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review the facility failed to ensure Resident #85's blood pressure medication was administered as ordered. This affected one resident (#85) of three residents reviewed for accidents. The facility census was 82.Findings include: Review of Resident #85's medical record revealed an admission date of 04/02/19 with diagnoses including dementia, dysphagia, and other peripheral vascular diseases.Review of Resident #85's medical record revealed the resident was rarely or never understood. Review of Resident #85's physician order dated 12/01/25 revealed the resident was to receive Metoprolol Tartrate (beta blocker) 50 milligrams (mg) by mouth two times a day for hypertension. The medication was to be held for systolic pressure less than 110 millimeters of mercury (mmHg).Review of Resident #85's Medication Administration Record (MAR) for March 2026 and 04/01/26 through 04/14/26 revealed the Metoprolol Tartrate was administered at 9:00 A.M. and 9:00 P.M. There was no evidence the resident's blood pressure was monitored around this time.Review of Resident #85's vital sign records revealed no evidence the blood pressure was monitored around 9:00 A.M. and 9:00 P.M.Interview on 04/16/26 at 8:33 A.M. with the Director of Nursing (DON) confirmed Resident #85's blood pressure was not being monitored as ordered.Review of policy ?Administration of Medications' dated 09/09/25 revealed when administering medications any parameters around drug administration should be noted.This violation represents noncompliance investigated under complaint 2746176 and 2693477.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy, the facility failed to ensure opioid medication was approved for the resident to take during a leave of absence for Resident #61. This resulted in an unobserved significant medication error for Resident #61. This affected one resident (#61) of one resident reviewed for pain. The facility census was 82.Findings include:Review of Resident #61's medical record revealed an admission date of 01/03/25 with diagnoses including opioid abuse, heart failure, anxiety disorder, bipolar disorder, depression, chronic viral hepatitis C, and unspecified mood disorder.Review of Resident #61's quarterly Minimum Data Set (MDS) 30 assessment dated [DATE] revealed the resident had intact cognition. Her medications included antianxiety, antidepressant, opioids, diuretics, and anticonvulsants.Review of Resident #61's plan of care dated 01/10/25 revealed the resident was on pain medication therapy related to pain. Interventions included administering analgesics as ordered, asking the physician to review medications if side effects persisted, monitoring for respiratory depression, observing and reporting for adverse reactions as needed, and pain medications to be crushed and put in applesauce. Review of Resident #61's plan of care dated 01/10/25 revealed the resident expressed pain or discomfort related to necrosis of right femur, right hip joint, and osteoarthritis. Interventions included evaluating the effectiveness of pain interventions, notifying the physician if interventions are unsuccessful, observing and reporting to the nurse any signs of nonverbal pain, pain medications as ordered, and observing and reporting to nurse resident complaints of pain. Review of Resident #61's physician order starting 09/10/25 revealed an order for Oxycodone 15 mg one tablet every four hours as needed.Review of Resident #61's note by Certified Nurse Practitioner (CNP) #266 dated 09/10/25 revealed the resident had returned from the hospital on [DATE] where she had been getting Oxycodone 20 mg and intravenous (IV) Dilaudid (opioid). They had significant difficulty weaning the resident off of IV medication in the hospital due to her refusal. The hospital had concerns with narcotic tolerance, and they recommended the facility wean her off of her oral pain medications. The physician discussed needing to decrease the dosage with the resident and she became very upset.Review of Resident #61's physician note dated 09/17/25 revealed they spoke with the resident regarding tapering her Oxycodone to 10 mg every four hours starting in two to four weeks.Review of Resident #61's progress note dated 11/21/25 at 7:40 P.M. revealed the resident was sent 17 Oxycodone pills to take home, on a leave of absence, and she left the facility with a family member.Review of Resident #61's controlled substance record revealed on 11/21/25 at 4:39 P.M. the resident received one Oxycodone and had 17 remaining. Written on this form was ?sent 17 pills with resident to home' with two signatures below it and ?resident received to take home 17 pill's with one signature below it.Interview on 04/16/26 at 12:28 P.M. with Regional Clinical Director #405 revealed the nurse and the resident signed the controlled substance record.Review of Resident #61's progress note dated 11/23/25 at 6:43 P.M. revealed Resident #61 called the facility and stated she was out of her pain pills and she was not given any other pills. She stated she would be returning to the facility later that day and she wanted to make sure the facility had her pain medication ordered when she returned.Review of Resident #61's progress note dated 11/24/25 at 2:04 P.M. revealed the resident returned to the facility and received as needed pain medication as requested.Review of Resident #61's medical record revealed no evidence the physician was notified that Resident #61 used 17 Oxycodone pills in less than 48 hours outside of the physician order. Review of Resident #61's physician note dated 12/12/25 revealed she continued on Oxycodone 15 mg every four hours as needed with a plan to wean as able.Interview on 04/15/26 at 10:30 A.M. with CNP #266 revealed Resident #61 went out to the hospital in September 2025, and her Oxycodone was increased with a plan to taper it. She reported the goal was to decrease the Oxycodone in the facility, however, this did not happen, she was unsure why. CNP #266 reported when the resident went on LOA's she was (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supposed to be getting half the frequency of Oxycodone. Since she was getting Oxycodone every four hours, she would get enough to have a dose every eight hours when she was out of the building. If she wanted to go on a LOA for more than two to three days, she would need to come back to the building to get more. CNP #266 confirmed she did not approve Resident #61 going on a LOA with 17 Oxycodone for Thanksgiving. She verified Resident #61 went through all 17 pills before she should have per her schedule. The physician should have been notified of this upon her return; however, the facility just returned her to her normal Oxycodone schedule.Interview on 04/15/26 at 1:30 P.M. with the Director of Nursing (DON) revealed there was no physician order to pull the Oxycodone for Resident #61's 11/21/26 LOA. The nurse said she got approval; however, this was not documented anywhere.Interview on 04/15/26 at 2:38 P.M. with Physician #270 revealed she was unavailable to talk at the time and would return the surveyor's call. No return contact was made for the duration of the survey.Interview on 04/16/26 at 10:59 A.M. with Licensed Practical Nurse (LPN) #183 revealed when a resident was going to go on a LOA for several days, they called the pharmacy and the pharmacy would send medications for the length of the absence. However, if a resident had narcotics the pharmacy would not make packages for it. The facility nurses would need to call the physician and get permission to send narcotics home and then they would send it from the resident's supply.Review of the policy ?Leave of Absence (Therapeutic Leave)' dated 09/09/25 revealed the facility will ensure continuity of care when a resident leaves the facility for therapeutic leave of absence. If medications were sent with the resident during a leave of absence the facility should complete the ?Release of Responsibility for Medication form.Interview on 04/16/26 at 12:28 P.M. with Regional Clinical Director #405 confirmed the LOA policy was not followed. This violation represented noncompliance investigated under complaint 2746176.

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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. Based on observations, interviews and policy reviews, the facility failed to wear proper hair and beard restraints when serving and preparing food , practice safe storage of utensils when preparing beverages and practice safe handling of food to prevent cross contamination. This had the potential to affect all but 10 residents the facility identified as receiving enteral feeding. The census was 82.Findings include:Interview on 04/14/26 at 11:30 A.M. interview with Food Service Director # 204 confirmed dietary workers are to wear hair nets or hats to cover hair and beard restraints if they have facial hair.Observation on 04/14/26 at 11:30 A.M. of the main residents' dining room ice bin revealed a large serving utensil used to place ice in the residents' drinking cups inside the ice bin. During concurrent interview with Dietary Aide #245 it was confirmed the utensil used to scoop the ice was stored inside the ice bin. Observation with Food Service Director #204 on 04/14/26 at 11:45 A.M. of the kitchen revealed [NAME] #221 walked away from the stove top and opened oven door and steamer doors with gloved hands and proceeded to prepare a mechanical diet plate of corn beef. With gloved hands she took one hand and held the corn beef to the plate while cutting it. Interview with Food Service Director #204 verified [NAME] #221 touched food to be served to residents with her hand that had a soiled glove on it. Observation on 04/14/26 at 11:45 P.M. during lunch service Aide #525 from the Assisted Living facility walked behind the service line to the cook with two-to-go containers requesting food for Assisted Living Residents. Aide #475 was not wearing a hair net, or a beard restrained to cover his hair on his chin. Verified by [NAME] # 223.During the observation care aide # XXX from the assisted living was obwserved to enter the area and walk behind the service line to the cook with two meal to do containers requesting foood for assisted living residents. Care Aide # Xx did not have a beard or hair covering im place. Interview with [NAME] #223 at the time of othe observation confirmed the care aide was not wearing a beard of hair covering. Observation on 04/15/26 from 11:15 A.M. to 12:00 P.M. of lunch service line revealed [NAME] # 223 routinely pulled his beard covering up from neck to his chin, ensuing his beard was covered. He did not wash his hands after readjusting the cover. During concurrent interview with Food Service Director # 204 it was confirmed [NAME] #223 had to keep adjusting the beard covering during tray line to ensure his beard was covered and did so with his hand and did not perform hand hygiene after adjusting the beard covering. Review of the Facility's policy Prevention of Cross Contamination, dated 05/01/25 , Iced used in connection with food and drink will be obtained from a sanitary source and handled and dispensed in a sanitary manner. Ice scoop will be stored in a designated holder .Review of the Facility's policy Resident Dining Services , dated 04/29/25, during tray setup, food should not be handled with bare hands, gloves should be worn or utensils used to avoid any contact with bare hands and subsequent cross contamination. Review of the Facility's policy Safe Food Handling, Associates shall wash their hands accordance with the Hand Hygiene Policy and current Food Code Guidelines before handling or consuming food including working with clean equipment and utensils and after touching the hair or mouth, after handling soiled equipment or utensils and during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks.Review of the Facility's policy Associate Conduct and Dress Code, dated 04/28/25. Dietary staff must wear hair restraints(e.g., hairnet, hat, and /or beard restraint) to prevent hair from contacting food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interview, and review of facility policy, the facility failed to follow infection control procedures for a resident requiring enhanced barrier precautions this affected one (#04) and the facility failed to ensure staff followed neutropenic precautions which affected one (#42) . Five residents were reviewed for infection control procedures. The facility census was 82. Findings Include: 1.Resident #04 was admitted [DATE] and had diagnoses that include obstructive uropathy, chronic kidney disease (stage IIIA), and chronic systolic congestive heart failure. Review of the Resident's Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicated the resident was cognitively intact and had an indwelling catheter. Review of the Resident #04's care plan completed 02/05/26 revealed Resident #04 had an indwelling catheter related to urinary retention and was at risk of infections. Enhanced Barrier Precautions (EBP) are an intervention listed to reduce the risk of infections with an indwelling catheter. Review of Resident #04's medical record revealed orders for EBP due to Foley Catheter use written on 01/20/26. Observation of Resident #04's room was conducted on 04/14/2026 between 10:19 A.M. and 11:16 A.M. Certified Nurse Assistant (CNA) #177 was observed at 10:19 A.M. entering the room of Resident #04 and Resident #56 for the purpose of giving each resident a bed bath. CNA #177 was observed entering room with patient gowns and trash bags. Upon entering the room, CNA #177 was not wearing a gown and did not stop to don gown, gloves, or mask from drawers sitting outside the Residents' room. CNA #177 exited the Resident's room about 11:16 A.M. not wearing a gown and carrying three trash bags. Used gloves were visible in one of the trash bags. Interview with CNA #177 at approximately 11:16 A.M. on 04/14/26 confirmed that she had given both residents a bed bath and CNA #177 confirmed she did not wear a gown during the bed bath for Resident #04. Review of the facility policy titled Enhanced Barrier Precautions (revised 08/19/25) defines EBP as an infection control intervention that employs targeted gown in glove use during high contact resident care activities. The policy defines bathing as a high contact resident activity requiring gown and glove use. The policy states that residents with indwelling medical devices are indicated for EPB. 2.Review of Resident # 42's medical record revealed an admission date of 07/21/25 with diagnoses that included but were not limited to multiple myeloma, agranulocytosis secondary to cancer chemotherapy, hypertension, peripheral vascular disease, obesity and congestive heart failure. Review of Resident #42's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of nine indicating cognitive impairment. He required assistance from staff with transfers, toileting hygiene, bathing and mobility. Review of Resident # 42's progress notes dated 07/30/25 revealed orders for the resident to be placed on neutropenic precautions. (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	Review of Resident # 42's physicians orders on 04/15/26 revealed no order for neutropenic precautions. Further review revealed an order for chemotherapy infusion every Thursday. Observation on 04/13/26 at 9:30 A.M. revealed Resident # 42's room door opened with neutropenic precautions signage on the door. Observation on 04/14/26 at 1:28 P.M. revealed Receptionist #152 walked into Resident #42's room with no mask and delivered a package. When Receptionist #152 exited the room, she verified she should have had a mask on and did not put wear one to go into Resident #42's room. Observation on 04/14/26 at 1:32 P.M. revealed Laundry Assistant #125 walked into Resident # 42's room with no mask and delivered his laundry. When Laundry Assistant # 125 was interviewed at the time of the observation and verified she entered the residents' room with no mask on adding she forgot to put on personal protective equipment. Interview on 04/14/26 at 1:39 P.M. with Resident # 42 revealed he was on neutropenic precautions because he goes out to chemotherapy twice a week. He stated sometimes staff wear masks and sometimes they don't. Resident # 42 also stated his room door used to be closed all the time and he preferred it to be left open. Interview on 04/14/26 at 1:45 P.M. with Director of Nursing (DON) confirmed staff should wear masks when entering neutropenic precautions rooms. She confirmed they were aware of staff entering with no masks and they plan to move signage for better view. Review of facility policy titled protective precautions (reverse isolation) dated 02/15/21 revealed protective precautions will be initiated at the recommendation of the attending or consulting medical provider. Also, a private room should be used when possible. Ideally, the door should be kept closed. The door may be left open if necessary, for resident safety. It also states personal protective equipment (PPE) will be worn in the room as needed by associates and visitors. This violation represents noncompliance investigated under complaint 2693477.