STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425106	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartland Health Care Center - Greenville East	601 Sulphur Springs Road Greenville, SC 29617

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review, the facility failed to store, prepare, and serve food under accepted sanitary conditions due to lack of regular cleaning of the food preparation area, placement of non-resident food items in the walk-in cooler and removal of expired items from the food supply. The deficient practice had the potential to affect 119 of 122 residents receiving oral diets.Findings include:Review of the facility policy titled, Sanitization, with a revision date of November 2022, revealed Policy Statement - The food service area is maintained in a clean and sanitary manner. Policy Interpretation and Implementation All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris and protected from rodents and insects.All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners are kept in good repair.All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions.Review of the facility policy titled, Policy on Pot Holders [sic] and Oven Mitts with Frays or Holes, revealed Pot holders [sic] and oven mitts used in the dietary department must be maintained in safe, clean and intact condition at all times. Any items showing frays, holes, tears, exposed inner padding, loose stitching, scorch marks, melted areas, thinning fabric and excessive wear shall be immediately removed from service and replaced. Damaged pot holders [sic] or mitts may not provide adequate heat protection and may also trap food residue, moisture, and bacteria, making them unsuitable for continued use in a foodservice environment.Observation and interview with the Dietary Director (DD) during the initial kitchen tour on 06/16/26 at 11:10 AM revealed in the dry food storage area a tub of vanilla frosting opened on 03/03/26 and with a Use By date of 06/06/26 and two large bags of vanilla wafers with a Best By date of 04/13/26. Fallen food crumbs, other debris, and soil were visible on the floor of the dry food storage room along with several dead insects. Other dried substances were observed smeared on the shelving.Further observation of the facility's one walk-in cooler revealed there was no backup thermometer placed inside the cooler and water was pooled on the floor. Three cans of soda belonging to an employee(s) were on a shelf inside the cooler.Observation along with the DD on 06/17/26 at 11:21 AM revealed three torn and soiled potholder gloves being used in the kitchen. The DD stated he had more and would replace them. Further observation of kitchen area revealed buildup of food spillage/grease, soiled saucers stored on bottom shelf of food prep areas. Food debris was also inside the storage drawers of the food preparation tables.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and policy review, the facility failed to maintain the operation of the walk-in freezer in a manner to prevent accumulation of ice buildup along the walls and on the food stored within. The deficient practice had the potential to affect 119 of 122 residents receiving oral diets.Findings include:A review of the 2022 Food Code published by the U.S. Food and Drug Administration found: Chapter 4. Equipment, Utensils, and Linens . 4-501.11 Good Repair and Proper Adjustment. Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk. For example, refrigeration units in disrepair may no longer be capable of properly cooling or holding time/temperature control for safety foods at safe temperatures.Observation and interview during the initial tour of the kitchen on 06/17/26 at 11:10 AM with the Dietary Director (DD) revealed the freezer, which was accessed from inside the walk-in cooler, had a buildup of ice and condensation on boxes, walls and surfaces with the ice being inches thick in some places. The DD stated a work order had been put in for repairs to the freezer and it was supposed to have been fixed.Review of a Summary of Work Performed dated 06/3/26 from the freezer service provider revealed the following, After arriving at the customer's location, checked in with [facility staff name]. Here today to service the walk-in freezer customer stated that there was ice buildup inside. There's a lot of ice inside of the box primarily around the fans on further inspection I found a few concerning issues, one being that the fan was damaged and needed to be replaced. The other was that the defrost time had an unusually long period of defrost this can cause excess moisture inside of the box. Defrost times have been reset to 4 times a day for 15 minutes each. One of the employees told me that they have been keeping cooler and freezer doors open for extended periods of time, sometimes exceeding one hour. They thought doing this would help reduce ice buildup in the freezer, however this has the opposite effect. New fan blade was installed. Ice was removed from the fan guards. The unit is running well at this time holding temp [temperature] below 0 degrees SH=20 SC=10 Checked out with [facility staff name [sic].During an observation and interview of the kitchen with the Operations Assistant (OA) on 06/18/26 at 9:25 AM the concern with the accumulation of ice in the freezer was verified. The OA also reported that she had attempted to remove the buildup, but it did not fix the problem.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, staff interviews, and policy review, the facility failed to ensure each resident's needs were met by failing to ensure an appropriate usable call light was in reach and available for use for one of one sampled resident who needed a soft touch call light instead of the regular push button call light, Resident (R)13.Findings include:Review of an undated facility policy titled, Signal System Policy, found: Guideline: 1. Be sure the call light is plugged in at all times. 2. Call light shall be placed within the reach of the resident. 3. Any call light not working appropriately will be reported immediately to supervisor. 4. Call lights will be answered as soon as possible. 5. For residents unable to utilize the call light, staff will monitor these residents frequently by making rounds. 6. If call light system becomes inoperable at any time, bells will be distributed to each resident for use to signal staff of needed assistance. For residents unable to utilize the call bell, staff will monitor these residents frequently by making rounds.On 06/16/26 at 12:15 PM, R13's call light was observed on the floor under the bed.On 06/16/26 at 12:40 PM, the Unit Manager for the 600 Unit was in the room with this surveyor. The Unit Manager pulled the call light from underneath the bed, cleaned it with a sani-wipe and placed it on top of the sheets where R13 was in bed. The call light was a standard push button call light which required the resident to push the red button on the end of the cord when assistance was needed. The Unit Manager stated R13 should always have his/her call light in reach. R13 was observed to be wearing bilateral hand splints. The Unit Manager stated R13 wore the splints for eight hours daily. When the Unit Manager was asked if R13 could use the call light while wearing the hand splints, she stated she did not think so. When asked if R13 ever had a different type of call light, the Unit Manager stated that R13 used to have a soft touch pad call light that all he had to do was to bump the pad when assistance was needed. The Unit Manager stated she did not know why R13 no longer had the soft touch pad call light.On 06/17/26 at 10:09 AM, the Director of Nursing (DON) stated during an interview that R13 was able to move his arms and had the capability to use a soft touch pad call light but was not physically able to use a push button call light. The DON stated the facility was in the process of having a new call light system installed and the company had provided call light cords but soft touch call lights were not available, and the facility did not have any in the building. The DON confirmed R13 did not have the ability to pick up and ring a handheld bell. The DON stated the company installing the new call light system had not provided soft touch bells for the new system. The DON stated she had instructed the Operations Assistant (OA) to order some as other residents could possibly benefit from them also. The DON stated she did not know long R13 had been without his soft touch call light, but would be first on the list to get one when the order came through. The DON further stated she would speak to nursing staff and have them make frequent rounds to check on R13 to ensure his needs were being met.On 06/17/26 at 1:00 PM, the OA reported that he had ordered 10 soft touch call lights last week but they had not arrived yet. Later, the OA presented for review a message from the call bell installation company dated 06/17/26 at 1:51 PM, that stated the order would be shipped on 06/18/26. Since the order had not yet shipped, R13 would not have access to a call light that he would be able to use until the order arrived from a remote location.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **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 the facility Code Book was updated to accurately reflect the resident's current code status of Full Code after the physician's order was changed from Do Not Resuscitate (DNR) to Full Code. The Code Book was identified by staff as a primary resource used to determine code status during an emergency. This affected one of 24 sampled residents reviewed (Resident (R) 14).Findings include:Review of the facility's policy titled, Emergency Procedure - Cardiopulmonary Resuscitation and Basic Life Support, dated 2001, noted: Policy Statement [:] Personnel are certified in cardiopulmonary resuscitation (CPR) for healthcare providers and basic life support (BLS), including defibrillation for victims of sudden cardiac arrest. General Guidelines [:] 1. If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a staff member who is certified in CPR for healthcare providers/BLS will administer CPR unless: a. it is known that a do not resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual.Preparation for Cardiopulmonary Resuscitation.g. Document advance directives in the resident medical records and educate staff on how to access this information. h. Provide clear instructions for staff regarding how to determine code status during an emergency.Review of R14's Face Sheet indicated that the resident was admitted to the facility on [DATE], and readmitted on [DATE] following a hospitalization, with diagnoses that included vascular dementia.Review of R14's hand-written physician orders, located under the Physician Orders tab, found an order dated [DATE] which read, DNR. Does not have decisional capacity.Review of the facility document titled, Physician's Certification of Decisional Capacity, noted: We hereby certify that we have determined upon physician examination that this resident [R14] is unable to exercise his or her rights in making Health Care Decision because of the following diagnosis.mood disorder[.] Extent and duration of decision making[:] permanent all medical decision, [sic], signed and dated by the Physician on [DATE].Review of R14's Advanced Directives form titled, Resident/Family Consent for Cardiopulmonary Resuscitation, noted: I understand that CPR constitutes an extraordinary measure and SHOULD NOT be done on [R14], [sic] the form noted verbal consent by the resident's representative, and was signed and dated by two witnesses on [DATE]. Review of R14's updated Resident/Family Consent for Cardiopulmonary Resuscitation, noted: I understand that CPR constitutes an extraordinary measure and SHOULD be done on [R14] [sic]. The form noted verbal consent by the resident's representative and was signed and dated by two witnesses on [DATE].During an interview on [DATE] at 1:05 PM, Licensed Practical Nurse (LPN) 1 stated that the staff rely on a Code Book kept at the nursing station to determine a resident's code status if the resident is unresponsive, in an emergency. LPN1 stated, The staff rely on the code book as the most reliable source in an emergency to see if the resident is full code or DNR [sic].During an observation and interview on [DATE] at 1:07 PM, LPN2, the Manager of 500 Unit, retrieved a large red binder titled, Code Book, from the nursing station. LPN2 opened the book and located R14's Advance Directive Sheet, which read, Do Not Resuscitate [DNR]. LPN2 stated that it was Social Service staff's responsibility to update the Code Book with the most accurate code status based on the Advance Directive education provided, a signed consent from the resident/resident representative, and a Physician's Order. LPN2 verified that R14's Physician Order dated [DATE] revealed an active order for a Full Code Status not a DNR status and that the Code Book, LPN2 described as the staff's most reliable resource for determining the resident's code status during an emergency, was not accurate. LPN2 admitted that not performing CPR during an emergency as R14's legal representative requested could have led to imminent harm or death.During an interview on [DATE] at 1:15 PM, Certified Nursing Assistant (CNA) 3 stated, We can log in and see the code status in our POC [Point of Care], but if we want the most accurate information [code status], the [Code] (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	book would probably be it [sic].During an interview on [DATE] at 1:54 PM, the Social Services Director (SSD) confirmed that R14's DNR Code Status in the Code Book was not accurate and that there was an active order for a Full Code Status from [DATE]. The SSD admitted that they were responsible for updating the Code Book on each Unit with any changes. The SSD stated, I didn't update the Code Book, [R14's] paperwork [Full Code Status orders and consent] was buried under a bunch of paperwork on my desk. It just got lost and I didn't do it.During an interview on [DATE] at 2:51 PM, the Director of Nursing (DON) stated that the Code Book was used by staff to confirm a resident's code status in an emergency. The DON stated, It should be done as soon as possible, in a timely manner, when we get the order. The Social Worker is usually the one that updates the Code Book, if she is off, there is always someone covering, usually the Discharge Planner. They would assume that roll. Staff can check on the computer [the resident's medical record] but they are relying on that Code Book to be accurate. The DON admitted that that not performing CPR during an emergency as the R14's legal representative requested, could have led to imminent harm or death.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review, and staff interviews, the facility failed to ensure a resident who was fed by enteral means, received the appropriate treatment and services to ensure adequate nutrition to prevent complications such as aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and nasal-pharyngeal ulcers for one of one resident reviewed whoreceived nutrition via a percutaneous endoscopic gastrostomy tube (G-tube), (Resident (R) 13).Findings include:On 06/17/26 at 10:09 AM, during an interview with the Director of Nursing (DON), she stated the facility did not have a policy regarding the labeling of tube feeding formula.On 06/16/26 at 12:40 PM, while touring the room of R13, a container of tube feeding formula was observed on a pole beside the bed. The container had a manufacturer's label that identified it as Jevity 1.5. The formula was connected to a G-tube in the abdomen of R13. The formula was infusing via a feeding pump at 70 milliliters (ml) per hour (hr) with water flushes to infuse at 175 ml every four hours. The label on the front of the formula did not identify who the formula was for (name of resident) and did not have a date or time or infusion rate to on the label. These areas were left blank. Additionally, there was a clear bag also hanging on the pole containing a clear liquid. This bag did not identify the contents of the bag, the name of the resident, date, time, or the rate the liquid was to infuse.A review of Physician's Orders for R13 revealed the following orders:05/05/26-check residual every shift and if >60 ml hold feeding;05/05/26-flush with 175 ml of water every four hours;05/05/26-Jevity 1.5 at 70 ml/hr-start at 6:00 PM and stop at 2:00 PM (20 Hours)A bottle of Jevity 1.5 contains 1000 ml of formula, the feeding was scheduled to infuse at 70 ml/hr for 20 hours a day and R13 should receive a total of 140 ml. Tube feedings are paused occasionally for resident care, repositioning and transfers. Since the bottle and the soft clear bag were not labeled as to date and time it was started, it would not be able to be determined how long the formula had been open and hanging on the pole. Since Resident #13 received more than one (1) 1000ml bottle a day, it was not possible to determine when this bottle of formula was initially put into service or how long it had been open.On 06/17/26 at 10:09 AM during an interview with the DON, she stated that all bottles of tube feeding formula and water should be labeled with the date and time. She further confirmed since tube feedings are often paused for care and repositioning that the start time of each bottle of formula could vary and should have a time written on each bottle and each bag of water flush so that the start time could be determined and it would not be left hanging for an extended period of time.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and review of facility policy, the facility failed to ensure that residents who required oxygen received care in accordance with professional standards of practice and physician orders for two of two residents, Resident (R) 13 and R49, sampled for oxygen therapy. Findings include: Review of an undated facility policy, titled, Oxygen Administration, revealed the policy did not address the administration of oxygen via a tracheostomy mask. The policy addressed the administration of oxygen via an oxygen mask over the nose and mouth, a nasal cannula or a nasal catheter. Review of an undated facility policy, titled, Departmental (Respiratory), noted: Purpose: 1. Review the resident's care plan to assess for any special circumstances or precautions related to the resident. 2. Assemble the equipment and supplies needed. 1. [sic] Check water level of any pre-filled reservoir every day, if ordered. 2. Change pre-filled humidifier bottle, if ordered every seven (7) days, or as needed. 3. Change the oxygen cannula and tubing every seven (7) days, or as needed. 4. Keep the oxygen cannula and tubing used PRN [as needed] in a plastic bag when not in use. 5. Wash external filters from oxygen concentrators with soap and water as needed. Rinse and squeeze dry. The policy did not address oxygen administered via a tracheostomy mask. The policy also did not instruct staff to ensure the oxygen concentrators were on and operating correctly to ensure the resident was receiving the supplemental oxygen ordered by the physician. On 06/16/26 at 12:40 PM, R13 was observed to have a tracheostomy and was wearing an oxygen mask/ tracheal collar over his tracheostomy site. The tracheal collar and the connecting tubing were not dated to the last time they had been changed. A humidified bottle was connected to the oxygen concentrator and the connecting tubing and was dated 06/14/26. The oxygen concentrator was in the off position and R13 was not receiving supplemental oxygen as ordered. The Unit Manager for the 600 Unit was present in the room and confirmed the oxygen concentrator was off and R13 was not receiving any oxygen. The Unit Manager stated the concentrator had been on earlier in the morning when she did rounds. The Unit Manager turned on the concentrator and set the level at five liters per minute. The Unit Manager also confirmed the tracheal collar and connecting tubing were not dated as to when they were last changed. The Unit Manager checked R13's oxygen saturation, and documented it as 93%. Review of Physician's Orders for R13 revealed orders as follows regarding his tracheostomy: 05/05/26 Trach and Ambu bag at bedside 05/05/26 O2 (oxygen) at five liters/minute via tracheal collar continuously every shift. 05/06/26 Suction as needed 2. A review of R49's medical record revealed R49 was admitted to the facility on [DATE]. A record review of R49's Physician's Orders revealed the following: Oxygen @ (at) 3L(liters) per nasal cannula-continuously every shift for hypoxia; change oxygen tubing every night shift every Sunday. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #49's diagnoses included acute respiratory failure with hypoxia and obstructive sleep apnea. A review of R49's current Significant Change Minimum Data Set assessment, with an Assessment Reference date of 03/24/26, revealed a Brief Interview for Mental Status score of three, indicating the resident had severely impaired in cognition. In an observation and interview on 06/16/26 at 2:25 PM, R49 was participating in activities in the dining room while utilizing oxygen at 3L per nasal cannula. Registered Nurse (RN) 4 stated the resident's oxygen tubing was dated 06/08/26. RN4 stated per facility policy, oxygen tubing was changed every Sunday. RN4 stated the resident's tubing should have a date of 06/14/26. RN4 confirmed policy and procedure was not followed for changing oxygen tubing. In an interview on 06/18/26 at 10:50 AM, the Director of Nursing (DON) stated oxygen tubing was changed every Sunday night on 3rd shift and as needed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, review of narcotic records, staff interview, and review of facility policy, the facility failed to establish a system of records of disposition of an injectable multi-dose vial of a Schedule III Controlled Drug in sufficient detail to enable an accurate reconciliation when passing responsibility of controlled drugs from one nurse to another. Findings include:Review of an undated facility policy, titled, Narcotics, Controlled Substances, and Preventing Drug Diversion, revealed: All medications are stored in a secure manner, as outline in other policies. Special storage and security procedures will be followed to protect controlled substances (narcotics, etc) and to help prevent drug diversion. Procedure: .2. A Narcotic Count Sheet will be maintained for all narcotic medications. a. When a narcotic is received in the community, it is counted by two staff members and added to the narcotic sheet with the current medication count reflected in the amount on hand. b. Each time a resident receives assistance with self-administration of a narcotic, this is documented and the amount of medication on hand is updated on the Narcotic Count Sheet. c. At the end of each shift, the staff member responsible for medication completing his/her shift, and the staff member responsible for medications who is starting his/her shift, count all narcotic medications and confirm that the amount on hand matches was [sic] it listed on the Narcotic Count Sheet for each medication. Both staff members will sign a Narcotic Reconciliation Sheet confirm the accurate count of narcotics on hand. d. Any discrepancies are immediately reported to the Administrator.On 06/16/26 at 12:25 PM during reconciliation of narcotics on the medication storage cart for the 600 Unit, a bottle of testosterone cypionate Injection 1000 milligrams (mg) per milliliter (ml), (a schedule III narcotic), a 10 ml multidose vial for R1 was maintained in the narcotic lock box. The Narcotic Count Sheet documentation noted the bottle contained seven ml. The bottle was not scored or labeled to indicate how much was in the bottle. The bottle was a made of clear glass with only the manufacturer label and no other markings. The prescription label for the medication was on the box. The medication label on the box containing the multidose vial of testosterone cypionate injection for R1 had instructions to administer 0.75 ml intramuscular (IM) once a week. The narcotic sign out sheet indicated four does had been administered over the past four weeks. Licensed Practical Nurse/Supervisor (LPN/S) 7, who was conducting reconciliation, stated he was unable to tell how much was left in the bottle but when shift counts were conducted, the nurses just went by what was recorded on the narcotic sign out sheet. LPN/S7 stated, since the bottle was not scored or marked in any way, there was no way to determine how much remained in the bottle of testosterone cypionate injection.Review of the medical record, under the Physician's Order tab, for R1 revealed a Physician's Order dated 06/06/25 for testosterone cypionate injectable 1000 mg/ml. Inject 0.75 ml intramuscularly one time a day every seven day(s) for low testosterone.On 06/17/26 at 10:09 AM, during an interview with the Director of Nursing (DON), the medication cart was revisited on the 600 Unit. The clear unscored and unmarked bottle of testosterone cypionate injectable remained in the narcotic box. The DON confirmed the count could not be verified. She said pharmacy would need to be contacted to request a container that the remaining amount could be verified when the reconciliation took place at shift change. The DON stated she could not determine by looking at the bottle how much of the medication remained in the bottle.On 06/17/26 at 10:16 AM LPN/S7 stated he had contacted pharmacy and was told that the clear unscored and unmarked bottle was the only way the medication was packaged. The DON, who remained present, stated she would contact pharmacy to see what the options were so that nurses could complete the narcotic reconciliation accurately.

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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	Provide and implement an infection prevention and control program. Based on observations, interviews, and policy review, facility staff failed to implement infection control procedures when delivering a meal tray to a resident on isolation precautions, specifically for Resident (R)3.Findings include:Review of the facility's policy titled, Isolation - Transmission-Based Precautions & Enhanced Barrier Precautions, revised September 2022, revealed, Policy Statement - Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents . 5. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. The signage informs the staff of the type of CDC [Centers for Disease Control and Prevention] precaution(s), instructions for use of PPE [personal protective equipment], and/or instructions to see a nurse before entering the room period Signs and notifications comply with the resident's right to confidentiality or privacy.Review of the facility's policy titled, Food Delivery for Isolation Rooms, undated, revealed Purpose - To ensure the safe handling, delivery, collection, and disposal of meal trays for residents on isolation precautions while minimizing the risk of infection transmission and maintaining resident dignity and nutritional care. Scope - This policy applies to all dietary, nursing, environmental services, and other staff involved in meal service for residents under isolation precautions. Policy Statement - Residents on isolation precautions shall receive meals in a manner that prevents cross-contamination and complies with infection prevention and control standards. Staff shall follow the required personal protective equipment (PPE) and hand hygiene procedures when delivering and retrieving trays.Review of the clinical record revealed a Physician's Order dated 06/12/26 which placed R3 on contact isolation precautions through 07/24/26. Corresponding signage and equipment were posted outside of the resident's room door.During an observation on 06/16/26 at 12:24 PM, Certified Nursing Assistant (CNA)6 was observed entering the room of R3 to deliver the lunch meal tray without donning any PPE.In an interview on 06/16/26 at 12:40 PM, CNA6 reported that PPE was not required as she was not going to be providing care.In a follow-up interview on 06/16/26 at 12:45 PM, Licensed Practical Nurse (LPN)5, the unit's Nurse Manager, confirmed that PPE was required due to R3 being on contact isolation precautions.In an interview on 06/18/26 at 9:55 AM, the Director of Nursing (DON) acknowledged staff should be donning PPE before entering and doffing PPE before exiting resident rooms for residents on contact isolation precautions. The DON also confirmed that R3's meal tray with the reusable dishware, was placed back onto the cart to be returned to the kitchen and that was also an Infection Control concern.