STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435043	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spearfish Canyon Healthcare	1020 N 10th Street Spearfish, SD 57783

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure a homelike environment for one of one sampled resident (39) due to the noise level in his room and that one of one sampled resident (61) had a hand towel available to dry himself after he had used his handwashing sink. Findings include: 1. Observation on 8/26/25 at 3:50 p.m. in resident 61's room revealed: Certified nurse aide (CNA) L assisted the resident in his bathroom after he had used the toilet. The resident used a grab bar beside the toilet to hold himself up while CNA L completed his peri-care, helped him with his clothing, and transferred him to his wheelchair with assistance from the resident's wife. There was a wall-mounted soap dispenser and paper towel dispenser near the resident's hand washing sink. It was just outside of his bathroom. CNA L had used that sink to wash and dry her hands after she exited the bathroom. She had not reminded or assisted resident 61 to wash his hands after he had exited the bathroom. There were no cloth towels on the towel rack that was mounted on the side of the countertop sink. There was a wadded-up washcloth that sat on top of the sink counter. Interview on 8/26/25 at 4:00 p.m. with resident 61 and his spouse revealed that the spouse had asked staff at different times for a clean washcloth and hand towel to be left on the towel rack for the resident to use, but that request was inconsistently accommodated. The resident confirmed he was able to independently use his handwashing sink. He was able to reach the paper towels and the soap dispenser. He preferred using cloth towels rather than paper towels because he had used cloth towels at home. Observations on 8/27/25 at 8:30 a.m. in resident 61's room revealed that same used washcloth observed above remained on the sink's countertop. There were no cloth towels on the towel rack. At 1:50 p.m., the used washcloth had been removed and not replaced with a clean one. There were no cloth towels on the towel rack. Interview on 8/27/25 at 2:05 p.m. with CNA L revealed it was her responsibility to ensure resident 61 had a clean washcloth and hand towel on his towel rack to use. That had not occurred. Interview on 8/27/25 at 2:15 p.m. with director of nursing (DON) B revealed she had not known that resident 61's washcloths and hand towels were not consistently placed on the resident's towel rack for him to use as he preferred. His preference for using cloth towels to wash and dry his hands was not accommodated, but it should have been. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the provider's revised 6/10/25 Safe and Homelike Environment policy revealed 4. The facility will provide and maintain bed and bath linens that are clean and in good condition. Based on observation, interview, record review, and policy review, the facility failed to provide a homelike environment for one of one resident (39) due to a very loud pressure valve release noise from bulk oxygen tanks placed directly outside the wall of the resident’s room. 2. Observation and interview with resident 39 in his room on 8/26/25 at 5:03 p.m. revealed: *He was the only occupant of the room. *He preferred to lie flat in his bed for much of the day due to chronic thoracic (middle section of the spine) pain. *He liked to listen to books on tape but would also watch television sometimes. *His bed was placed with the long side against the exterior wall of the room. *Approximately 11 large bulk oxygen tanks were grouped along the exterior wall of the room. *The tanks intermittently released pressure with a loud, aggressive hissing noise. -Each tank release noise lasted from 5 to 15 seconds. -The noise level interrupted the ability to converse or hear the television. *He wore headphones a lot to help block the noise. *He said the tanks’ release noises interrupted his thoughts, activities, and disturbed his sleep. *He felt the tanks’ release noise increased his anxiety and caused him to be startled frequently. *He stated he hated the noise and it was often louder than the one experienced at that time. *The noise had been present since he admitted to the facility last year. *He had not asked for a different room as he was grateful to be there. *He felt that the noise aggravated his anxiety and negatively affected his mental health. Observation on 8/27/25 from 9:30 a.m. to 9:45 a.m. outside of resident 39’s room revealed: *There was no pattern to how often the tanks’ release noise would occur. *The tanks’ release noise occurred three times during approximately 15 minutes of observation. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The tanks’ release noise level varied but could be heard and clearly identified in the hall 30 feet from resident’s room with the room door closed. Review of the resident 39’s electronic medical record (EMR) revealed: *Resident 39 was admitted on [DATE]. *His admitting diagnoses included: *Generalized Anxiety Disorder (a chronic mental health condition characterized by excessive and persistent worry and anxiety that is difficult to control.) *Post-traumatic stress disorder (PTSD) (a mental health condition that’s develops after experiencing or witnessing a traumatic event.) *Schizotypal disorder (a mental disorder characterized by thought disorder, paranoia, and social anxiety.) *Other schizoaffective disorder (a mental health condition marked by a mix of symptoms such as hallucinations and delusions, and mood disorder symptoms such as depression.) *He had a Basic Interview for Mental Status (BIMS) assessment score of 14, which indicated his cognition was intact. Review of resident 39’s care plan revealed: *Resident 39 had screened positive for PTSD related to prior Vietnam war service. *Resident had triggers identified to a history of trauma that included excessive or prolonged television (TV) viewing, especially TV programming with action scenes. *Resident 39 experienced stressful or startled responses when others walked quickly or stomped behind him. Interview on 8/27/25 at 9:30 a.m. with Social Services Designee H regarding oxygen tank release noise levels in resident 39’s room revealed: *She was not aware of the noise made by the bulk oxygen tanks releasing pressure. *She agreed that his PTSD and anxiety could be aggravated by that noise Interview on 8/28/25 at 8:40 a.m. with maintenance technician E revealed: *He was aware of the noises from the oxygen tanks releasing pressure. *He had not heard it from inside the resident 39’s room. *He had not thought about if the noise was disturbing resident 39. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*He thought residents would “probably get used to it.” Interview on 8/28/25 at 8:48 a.m. with certified medication aide (CMA) F revealed: *She was not aware of the oxygen tanks’ release noise in resident 39’s room. *She stated she “was probably used to it.” *She wouldn’t want a resident to be constantly disturbed. Interview on 8/28/25 at 9:30 a.m. with registered nurse (RN) G revealed she was not aware of the tanks’ release noises in resident 39’s room. Interview on 8/28/25 at 9:50 a.m. with resident 39 revealed: *The social worker had come to visit him about the tank noise on 8/26/25. *He had told her that the noise was extremely startling, increased his stress and anxiety, and interrupted his activities and thoughts. *The tank released while he was talking, startling both resident and this surveyor. *He was grateful to have a roof over his head, but was very happy to be moving to a new room away from the noise. Interview on 8/28/25 at 12:20 p.m. with administrator A revealed: *The bulk oxygen tanks had been placed in that location prior to her return to the facility approximately two years ago. *Now aware of the noise, they intended to move the tanks away from resident rooms. *They would not have a resident reside in that room until the tanks were moved. Review of the providers safe and homelike environment policy revealed: *”In accordance with residents’ rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. ” *”Comfortable sound levels” was defined to mean “levels that do not interfere with resident’s hearing, levels that enhance privacy when privacy is desired, and levels that encourage interaction when social participation is desired.”

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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. Based on observation, interview, record review, and policy review, the provider failed to implement a process that ensured an accurate accounting of daily fluid intake for one of one sampled resident (4) on dialysis with a physician-ordered fluid restriction. Findings include:1. Observation and interview on 8/27/25 at 8:15 a.m. with resident 4 revealed she was returning to her room from the dining room after breakfast. She was not available for an interview on 8/26/25 because she had been at dialysis for most of that day. She dialyzed on Tuesdays, Thursdays, and Saturdays. There were 13 bottled waters, a six-pack of soda, and a lidded cup with water inside it in her room. She had opened one of those bottled waters and drank from it during the interview. She stated her medical provider had told her she should be trying to get rid of fluid, and avoid drinking a lot of fluids. Review of resident 4's electronic medical record (EMR) revealed a 4/17/22 physician's order for: Fluid Restriction: 1500 cc [cubic centimeters] per day. Dietary: 320 cc 3 X [times]/day [per day]. Nursing: 120 cc 3x/day med [during medication] pass: 60 cc 3x/day. Interview on 8/27/25 at 3:20 p.m. with licensed practical nurse (LPN) R regarding resident fluid restrictions revealed that a Huddle Book was kept at the nurses' station. The huddle book was referred to by caregivers for resident-specific information, including which residents had fluid restrictions. Resident 4's name was on that fluid restriction list. Regarding the excessive number of fluids available to the resident in her room, LPN R stated a bottled water and a lunch were sent with the resident on her dialysis days. The resident often had not consumed the bottled water at dialysis and brought it back with her to her room. LPN R stated that those unused bottled waters should have been removed from the resident's room when the nurse had completed the resident's post-dialysis assessment. On 8/27/25 at 4:20 p.m., a copy of resident 4's fluid intake documentation for one week was requested from director of nursing (DON) B. Interview on 8/27/25 at 5:20 p.m. with DON B revealed that when a resident had a physician-ordered fluid restriction, that restriction was to be added to the resident's treatment administration record (TAR). Daily fluid intakes were to be documented, calculated, and monitored on that TAR to ensure compliance with the physician's order. Resident 4's fluid restriction order information had not been added to her TAR. Her daily fluid intake had not been calculated or monitored to determine if her fluid restriction was being followed as ordered. Review at that same time with DON B of the communication tool used between the provider and the dialysis unit revealed no noted concerns by either entity regarding the resident having potentially not followed her fluid restriction. DON B agreed that failing to follow the provider's processes for accounting for resident 4's fluid restrictions and not removing unnecessary fluids from the resident's room had placed that resident at risk for potential harm. Review of the provider's revised 5/2/25 Fluid Restriction policy revealed:1. The breakdown of a resident's fluid intake will be recorded on the medication record or other format as per facility protocol.4. Water will not be provided at the bedside unless calculated into the daily total fluid restriction or unless specifically ordered by the physician.

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, record review, and policy review, the provider failed to ensure:The whiteboard communication board in one of one sampled residents' rooms (61) was updated to reflect the amount and type of caregiver assistance required for him to safely transfer from his toilet to his wheelchair. The safety of one of one sampled resident (61) who was not transferred by one of one certified nurse aide (CNA) L as directed in the resident's care plan and the provider's huddle book (a communication tool that informs caregivers of residents' care needs), which may have increased his risk for falling and/or injury. Findings include: 1 Observation on 8/26/25 at 3:50 p.m. in resident 61's room revealed a wall-mounted whiteboard with the following information written on it: 7/17[/25]: SPT [stand pivot transfer-a staff person assists the resident to a standing position, and the resident then turns their body to move to another surface] w/FWW [front wheeled walker] assist X1 [assisted by one staff person]. There was a folded mat propped against the wall at the foot of the resident's bed.Continued observation revealed CNA L was with resident 61 inside his bathroom, assisting him off the toilet. Without first putting a gait belt around the resident's waist (a waist strap gripped by the caregiver and used as support for safe mobility and transfer), she lifted up on the resident's pants and verbally cued him to use the wall-mounted grab bar next to the toilet to help pull himself up off the toilet to stand. The resident had repeatedly stated he was too weak to pull himself up to stand. He called out for his wife to help.After hearing the resident call for her help, the resident's spouse entered the bathroom with a gait belt and handed it to CNA L. CNA L then placed the gait belt around the resident's waist. The gait belt enabled CNA L to provide the support resident 61 needed to come to a standing position, pivot, and lower himself onto his wheelchair seat safely. Interview on 8/26/25 at 4:20 p.m. with CNA L regarding the above transfer revealed she was expected to have used a gait belt whenever she had assisted a resident with a transfer. It was a standard safety and fall prevention intervention. She stated she referred to the information on the whiteboards in residents' rooms to know how to properly transfer the residents. She had not known who was responsible for updating the information on the residents' whiteboards.Interview on 8/26/25 at 4:30 p.m. with resident 61 and his spouse revealed that he had been awake early and had been busy throughout that day with therapy and outpatient appointments. His physical stamina was diminished. He had fallen since he was admitted to the facility. His bed was lowered at night, and the fall mat observed above was to be placed along the side of his bed at night, related to his risk for falling. Review of resident 61's electronic medical record (EMR) revealed his admission date was 4/17/25. His diagnoses included a right femur (upper leg/thigh) fracture and chronic obstructive pulmonary disease (a chronic breathing disorder).An 8/18/25 event note indicated: CNA stated she was attempting to transfer resident [61] from his bed to his wheelchair for toileting, his right leg slid forward causing [the] resident to be lowered to the floor onto his buttocks. There was no injury to the resident as a result of that fall. An 8/19/25 Fall Assessment-Post Incident score was 18. That indicated the resident was at high risk for falling.Review of resident 61's current care plan initiated on 4/18/25 revealed a focus area of Transfers/Bed Mobility/Ambulation. A revised 6/19/25 intervention for that focus area indicated resident 61 required extensive assistance of 1 staff person with bed mobility, transfers and ambulation. That intervention was revised again on 7/21/25 by director of rehabilitation C and indicated Assist X 2 [by two staff persons] stand pivot transfer [a staff member assists the resident to a standing position, and the resident then turns their body to move to another surface] with FWW [a front-wheeled walker] and [the use of a] gait belt. Interview on 8/27/25 at 9:30 a.m. with director of nursing (DON) B revealed the whiteboards in residents' rooms were to be maintained and updated by the therapy department. If the whiteboard was updated, those changes were documented on a Therapy to Care Plan-Communication Tool. Copies of that tool were distributed to the provider's Minimum Data Set (MDS) Coordinator, the DON, and the nurses' station. Nursing staff were to communicate those resident-specific changes to caregivers during shift changes. Copies of those tools were placed in a Huddle Book that contained resident-specific care information and was kept at the nurses' station for the caregivers to reference. Review of the above Huddle Book revealed a 7/17/25 Therapy to Care Plan-Communication Tool, signed by physical therapist Q, had indicated resident 61 required a 2 person stand pivot transfer with FWW and gait belt.Interview on 8/28/25 at 10:25 a.m. with physical therapy assistant (PTA) P regarding the 7/17/25 expectations for transferring resident 61, and the transfer information documented on his whiteboard revealed that the information on his whiteboard was outdated and not accurate. She confirmed resident 61 had required the assistance of two staff persons and the use of a

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the provider failed to ensure two of two observed medication refrigerators had not contained expired vaccines that were available for administration to the residents. Findings include: 1. Observation on 8/28/25 at 1:45 p.m. of the medication room refrigerator in the [NAME] Hall revealed: *Ten influenza vaccines had expired on 6/30/25. *One pneumococcal 13-valent vaccine had expired on 4/2025.Interview immediately after having identified the above expired vaccines with registered nurse (RN) G revealed:*She had thought that the night nursing staff had been checking for expired vaccines and medications.*She was unsure if there had been any other staff who were responsible for checking for expired vaccines and medications.2. Observation on 8/28/25 at 2:15 p.m. of the medication room refrigerator in the green hall revealed:*Three influenza vaccines had expired on 6/30/25.*One pneumococcal 13-valent vaccine had expired on 4/2025. Interview immediately after having identified the above expired vaccines with licensed practical nurse (LPN) I revealed:*She thought the pharmacist checked for outdated medication once a month.*She was not aware that those expired vaccines had been in the refrigerator.*She was unsure if the night nursing staff had been checking for expired medication. Interview on 8/28/25 at 2:30 p.m. with director of nursing (DON) B regarding the expired vaccines in the two medication room refrigerators revealed:*She was not aware there was expired vaccines in the two refrigerators.*She stated the consultant pharmacist was to check for expired medications and vaccines once a month.*All staff that administered vaccines should have checked the expirations dates.*The expired vaccines should have been removed and sent back to the pharmacy for drug destruction. Review of the provider's June 2025 Hazardous Waste Pharmaceuticals revealed:*Facility staff with approved access to pharmaceuticals will store, administer, and discard pharmaceuticals in accordance with relevant facility procedures.*Expired medications sent for drug destruction.

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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 observation, record review, interview, and policy review, the provider failed to ensure follow standard food safety practices to ensure:*One of one low-temperature dishwasher's temperature was consistently monitored and documented to ensure it met the required minimum wash temperature for sanitation of items used to prepare and serve food to the residents.Findings included:1. Observations on 8/26/25 at 10:32 a.m. and 10:37 a.m. in the kitchen revealed: *The logs for the dishwasher temperatures for August 2025 were hanging on the wall and included:-Columns to record Temp (temperature) for B (Breakfast), L (Lunch), and D (Dinner), Sanitizer Concentration (PPM) (parts per million), and Initials.-Those temperature columns had documented temperatures that ranged from 110 to 126 degrees F (Fahrenheit)--Thirty-six of those documented temperatures were not at the minimum required temperature of 120 degrees F.-For July 2025:-The dishwasher temperatures documented in the columns titled Temp (temperature) for B (Breakfast), L (Lunch), and D (Dinner).-ranged from 110 to 130 degrees F.--Five of those temperatures were not at the minimum required wash temperature of 120 degrees F.-There were had 41 out of 93 opportunities in July 2025 that did not have documented dishwasher temperatures. 2. Interview on 8/26/25 at 10:45 a.m. with dietary supervisor (DS) J revealed she:*Had been employed with the facility as the DS for only a short time.*Was unaware of the dishwasher's low wash temperature readings.*Stated she would call the service department that they lease the dishwasher from to schedule maintenance.-She was unsure of the last time the leased dishwasher had been serviced. 3. Interview on 8/27/25 at 1:55 p.m. with dietary aide K revealed she ran the dishwasher three times after breakfast before the water temperature reached 120 degrees F. 4. Further interview on 8/27/25 at 2:10 p.m. with DS J revealed she:*Had been employed with the facility as the DS since 6/25/25.*Called the service department that they lease the dishwasher from, and they informed her that they would only service the dishwasher if they had problems with the chemicals, not the water temperature.*Had the maintenance technicians inspect the dishwasher that day, and they advised her that the kitchen staff would need to run the dishwasher multiple times to get the water temperature to 120 degrees F.*Agreed there were several unrecorded temperatures on the dishwasher temperature logs.*Had been training new staff, and had forgotten to check the dishwasher logs. 5. Interview on 8/28/25 at 8:32 a.m. with maintenance technician E revealed he:*Informed the DS that the kitchen staff would need to run the dishwasher multiple times to reach the required temperature of 120 degrees F.*Was unaware of the dishwasher's low wash temperature readings before the DS informed him. *Had not been asked to perform maintenance on the dishwasher in the past few months. 6. Interview on 8/28/25 at 8:40 a.m. with administrator A revealed:*She was unaware of the dishwasher's low wash temperature readings.*She expected the kitchen staff to have notified the DS of the dishwasher's low wash temperature readings.*There had been no gastrointestinal outbreak in the facility. 8. Review of the provider's 6/15/25 Dishwasher Temperature policy revealed: It is the policy of this facility to ensure dishes and utensils are cleaned under sanitary conditions through adequate dishwasher temperatures. 4. For low temperature dishwashers (chemical sanitization):a. The wash temperature shall be 120 degrees F.b. The sanitizing solution shall be 50ppm (parts per million) hypochlorite (chlorine) on dish surface in final rinse.

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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 observation, interview, and policy review, the provider failed to ensure infection prevention and control practices were followed by:One of one observed certified medication aide (CMA) (M) who did not clean one of one sampled resident's (76) inhaler after it was used for medication administration.One of one observed certified nurse aide (CNA) (N) who did not complete hand hygiene (handwashing) during a transition in cleaning urine from the floor and handling one of one sampled resident's (63) catheter urine collection bag valve.One of one observed CNA (L) who had not reminded or assisted one of one sampled resident (61) to perform hand hygiene after he had used the bathroom.Findings include: 1. Observation and interview on 8/26/25 at 11:37 a.m. with CMA M after she had administered resident 76's medication through an inhaler revealed:Without first cleaning the mouthpiece of the inhaler, CMA M placed the uncleaned inhaler back into its box inside the medication cart.The box top was opened and stored with other residents' medications.She stated that she should have used an alcohol pad to clean the mouthpiece after it was used to mitigate the resident's risk of infection or cross-contamination, but she had not done that. 2. Observation and interview on 8/26/25 at 12:21 p.m. with CNA N in resident 63's room revealed:Resident 63 was seated in his recliner. There was a large amount of urine on the floor in front of and to the side of his recliner.After CNA N lifted the resident's pant leg, CNA N stated the valve of the resident's urinary catheter bag was not properly tightened and that caused the urine inside the catheter bag to leak out and onto the floor.CNA N performed hand hygiene, then put on a gown and a pair of gloves. He used cloth towels to absorb the urine from the floor. With those same gloved hands, CNA N adjusted the resident's urinary catheter bag valve and resumed cleaning the floor.CNA N stated he was not sure at what point in the above observation that he should have removed his gloves, performed hand hygiene, and put on a clean pair of gloves. He agreed that using unclean gloves while handling the catheter bag valve had increased resident 63's risk for infection. 3. Observation and interview on 8/26/25 at 3:50 p.m. with resident 61, after CNA L had assisted him to use the bathroom, revealed:CNA L exited the bathroom, removed and discarded her gown and gloves. Outside of the bathroom, there were wall-mounted paper towel and soap dispensers near the handwashing sink that she used to perform hand hygiene. She had not reminded or assisted the resident to perform hand hygiene after he had exited the bathroom.Resident 61 confirmed he was able to independently use the handwashing sink to wash and dry his hands. He had not always remembered to perform hand hygiene after he used the bathroom without staff reminding him. Interview on 8/27/25 at 2:05 p.m. with CNA L regarding the above resident observation revealed she had not reminded or assisted resident 61 to wash his hands after he had used the bathroom, but she should have. She agreed that resident hand washing after bathroom use was an important infection prevention intervention. Interview on 8/28/25 at 2:07 p.m. with Infection Preventionist O regarding the above observations revealed that she confirmed the above observed staff missed opportunities to mitigate the risk of infection. Review of the provider's revised 5/20/25 Administration of Metered-Dose Inhaler (MDI) policy revealed: 18. When all the ordered inhalations have been administered, remove the spacer (if used) from the MDI, and wash the spacer and mouthpiece according to the manufacturer's instructions. Review of the provider's revised 4/10/25 Hand Hygiene policy revealed: 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. That hand hygiene table included the following condition: When, during resident care, moving from a contaminated body site to a clean body site. A Glove Use policy was requested from administrator A on 8/28/25 at 3:10 p.m. At 3:45 p.m. on 8/28/25, administrator A stated the facility had no Glove Use policy.A Resident Hand Hygiene policy was requested from administrator A on 8/26/25 at 12:05 p.m. At 2:50 p.m. on 8/28/25, administrator A stated the facility had no Resident Hand Hygiene policy.