

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435048	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Avantara Groton		STREET ADDRESS, CITY, STATE, ZIP CODE 1106 North Second Street Groton, SD 57445	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to develop and implement a resident-centered baseline care plan within 48 hours of admission for four of five sampled residents (1, 3, 20, and 37) who were recently admitted .Findings include:1. Review of resident 3's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *His 11/19/25 Brief Interview of Mental Status (BIMS) assessment score was 13, which indicated his cognition was intact. *A 3/31/25 progress note stated, A copy of his admission summary note was provided to [the] resident. Baseline care plan was reviewed with [the] resident. Resident agrees and understands the baseline care plan. -The baseline care plan was reviewed with resident 3 three days after his admission to the facility. Review of resident 3's baseline care plan revealed focus areas of: *The new admission initial/interim care plan was initiated on 3/31/25. *Advanced directive (a document that expresses a person's health care wishes if they become unable to speak for themselves) status initiated on 3/31/25 identified the resident wished to be a full code. *Discharge potential and discharge planning initiated on 3/31/25 identified resident 3's discharge goal to return home after completion of therapy. *[Resident 3] require/s Enhanced Barrier Precautions [glove and gown use when providing contact care] related to: indwelling foley [urinary catheter] was initiated on 4/1/25. *[Resident 3] requires assistance with ADL's [activities of daily living] (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting) was initiated on 4/1/25. -Interventions within the resident ADL focus were, Assist resident with shower/bathing per schedule up to 2x/wk [two times per week]. [Resident 3] is able to voice preference of shower or tub bath initiated on 5/1/25. - Assist with application of appliances if needed (hearing aid, eyeglasses, dentures), Encourage (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	participation in ADL's, Keep call lights within reach when in bedroom or bathroom, initiated on 3/28/25. -Provide DME [durable medical equipment] -wheelchair and walker initiated on 4/1/25. *[Resident 3] has an ADL Self Care Performance Deficit and Impaired Mobility initiated on 4/8/25. -Interventions within the focus areas were, BED MOBILITY -total assist of 1, TRANSFER: partial/moderate, WALKING: partial/moderate- very short distances occasionally, DRESSING: partial/moderate for upper body dressing. Total assist for lower body dressing/footwear, TOILET USE: total assist of 1, PERSONAL HYGIENE/ORAL CARE: partial/moderate assist of 1. -All the interventions for resident 3's ADL self-care performance deficit and impaired mobility which identified the assistance required to safely care for resident 3 were initiated on 4/8/25, 11 days after he was admitted . 2. Interview on 12/9/25 at 2:40 p.m. with resident 37 revealed he did not recall if a staff member talked to him about his plan of care on his admission. Review of resident 37's EMR revealed: *He was admitted on [DATE]. *His 12/2/25 BIMS assessment score was 14, which indicated his cognition was intact. *He did not have a progress note in his EMR that indicated his baseline care plan had been reviewed with him or a resident representative. Review of resident 37's baseline care plan revealed focus areas of: *The new admission initial/interim care plan was initiated on 11/14/25. *Advanced directive (a document that expresses a person's health care wishes if they become unable to speak for themselves) status identified resident wish to be a full DNR that was initiated on 11/18/25. *Discharge potential and discharge planning was initiated on 11/18/25 that identified resident 37's discharge goal to return home after the completion of therapy. *[Resident 37] require/s Enhanced Barrier Precautions related to: straight caths [catheterizations] TID [three times a day] & [and] PRN [as needed] was initiated on 11/19/25. *[Resident 37] requires assistance with ADL's [activities of daily living] (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting) was initiated on 11/14/25. -Interventions within the resident's ADL focus that were initiated on 11/14/25: -Assist [resident 37] with shower/bathing per schedule up to 2x/wk [two times per week]. [Resident 37] will voice preference of shower or tub bath. (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Review of resident 20's EMR revealed: *She was admitted to the facility on [DATE]. *She did not have a documented intervention on her care plan until 11/14/25. *Her interventions for activities of daily living (ADL's) in her care plan included: -Assist with application of appliance if needed -Encourage participation in ADL's -Provide durable medical equipment [DME] if needed -Transfer: partial/moderate assist 5. Interview on 12/11/25 at 2:17 p.m. with certified nursing assistant (CNA) P revealed she: *Referred to a paper care plan for new admissions or if she did not know what cares a resident required. *Was also able to access a resident's care plan in the computer in the Kardex (a report of the resident's care needs and interventions). 6. Interview on 12/11/25 at 2:37 p.m. with licensed practical nurse (LPN) I revealed: *The paper care plan referred to by CNA P were printed from each resident's Kardex. *The information on the Kardex was based off each resident's care plan. *The nurse completed the baseline care plan during the admission process on the day the resident was admitted by selecting pre-scripted options on the admission assessment. *The boxes that the nurse checked on admission would then generate the baseline care plan. *Within the focus areas such as nutrition and activities of daily living (ADL) the interventions auto-populated to be the same for every resident. *LPN I verified that resident 1's discharge goal on his baseline care plan was *** and did not identify what resident 1's discharge goal was. 7. Interview on 12/11/25 at 3:13 p.m. with registered nurse [RN]/minimum data set [MDS] coordinator E revealed: *When a new resident arrives to the facility, the nurses fill out a UDA form [UDA or user-defined assessment, a series of questions related to the resident's care with options to choose from that apply to the resident]. -The assessment form has the same choices for every resident. (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Care planning is constantly in process; it begins the moment the resident is admitted to the facility and doesn't end until discharge or death. *The director of nursing [DON] will be responsible for holding the team accountable to initiating and completing the admission care plan within 48 hours and the long-term care plan by day 21 and updated as necessary thereafter. *Interventions act as the means to meet the individual's needs. The recipe for care requires active problem solving and creative thinking to attain, and clearly delineates who, what, where, when, and how the individual resident goals are being addressed and met. *Each staff member working with the individual resident is responsible to read, utilize and offer input to improve the care plan content ongoing. *A baseline care plan is started by nursing staff on the first day of admission to provide guidance to direct care givers as soon as possible after admission and completed no later than 48 hours after admission. Nursing, dietary, activities and social services staff complete formal assessments, interviews and observation and begin formulating the full care plan as soon after admission as possible. (These departments do have areas that need to be completed by the 48 hour deadline). *The areas that must be addressed in the baseline care plan include the minimum healthcare information necessary to properly care for a resident including but not limited to: initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, PASARR recommendation, if applicable.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 review, the provider failed to ensure five of five sampled residents' (4, 7, 8, 19, and 37) Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessments were accurately coded for the areas of weight loss, Pre-admission Screening and Resident Review (PASRR), insulin administration, and pneumococcal (pneumonia) vaccination status. Findings include: 1. Interview on 12/9/25 at 4:10 p.m. with resident 8 revealed she had a history of trauma and was receiving counseling services. Review of resident 8's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *Her diagnoses included delusional disorder (a mental illness where a person holds strong, false beliefs despite evidence to the contrary), anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), post-traumatic stress disorder (PTSD) (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), and bipolar disorder (mental condition causing extreme shifts in mood, energy, and activity levels). *She had a level I (1) PASRR completed on 2/14/25 due to a change in her medications. -The Level I PASRR stated, Your Level I screen was submitted for a potential status change. It shows that you have evidence of serious mental illness or an intellectual/developmental disability (IDD). However, your condition does not require further PASRR evaluation at this time because your serious mental illness or IDD treatment needs have not significantly changed since your previous PASRR Level II evaluation. -The facility should mark yes for question A1500 on the MDS 'Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition?' *There was no Level II PASRR in resident 8's EMR. *Item A1500 in section A of her 9/19/25 comprehensive MDS assessment was coded No to the question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? -Item A1500 in section A was coded No on resident 8's 4/28/22, 9/9/22, 6/20/23, 10/4/23, and 9/30/24 comprehensive MDS assessments. 2. Review of resident 4's EMR revealed: *He was admitted on [DATE]. *He had a diagnosis of diabetes (a condition involving disruptions in how the body regulates blood (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 11/17/25 she weighed 93.2 lbs., and on 10/17/25 she weighed 90.2 lbs., a weight gain of 3 lbs., this was 3.3% in one month. -On 8/15/25 she weighed 90.8 lbs., a weight gain of 2.4 lbs., a 2.65% on 11/17/25. -On 5/12/25 she weighed 95.6 lbs., a weight loss of 2.4 lbs., a 2.51% on 11/17/25. -The resident did not have a documented significant weight loss of 5% (percent) in 30 days or 10% in 180 days. 9. Review of resident 7's EMR revealed: *Her admission date was 6/6/25. *Review of her 9/12/25 MDS indicated she had a significant weight loss. *Her weight record documentation indicated that: -On 8/11/25 she weighed 97.0 lbs., on 9/9/25 she weighed 102.4 lbs., a weight gain of 5.4 lbs. in one month -On 6/6/25 she weighed 98 lbs., and on 9/9/25 she weighed 102.4 lbs., a weight gain of 4.4 lbs. in 3 months. -The resident did not have a documented significant weight loss of 5% (percent) in 30 days or 10% in 180 days. 10. Review of the CMS Long-Term Care Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 revealed section K Swallowing/Nutritional Status, page 4, definition for weight loss included: DEFINITIONS 5% WEIGHT LOSS IN 30 DAYS Start with the resident's weight closest to 30 days ago [from the ARD] and multiply it by .95 (or 95%). The resulting figure represents a 5% loss from the weight 30 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost weight. 11. Interview on 12/10/25 at 3:35 p.m. with RN/MDS coordinator E revealed: *Certified dietary manager (CDM) F was responsible for completing section K of the residents' MDS assessments. *She expected section K of the MDSs to be completed accurately. 12. Interview and record review on 12/10/25 at 4:01 p.m. with CDM F revealed: *She completed section K of the residents' MDS assessments. *She had limited training on how to complete the MDS. *She was aware there was an RAI manual but was not aware that there were instructions on how to complete section K of the MDS in that manual. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435048	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Avantara Groton		STREET ADDRESS, CITY, STATE, ZIP CODE 1106 North Second Street Groton, SD 57445	
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*After review of resident 19's EMR and 11/17/25 MDS, CDM F confirmed she miscoded resident 19's weight as a significant weight loss on the MDS, and it should have been coded as a weight gain. -She indicated she used resident 19's weight report information and did not use 30 days from the ARD of 11/17/25 to calculate resident 19's weight gain or loss. *After review of resident 7's EMR and 9/12/25 MDS, she stated she marked the resident's weight loss in error on the MDS, and resident 7 had a weight gain. She was not sure why she coded that error. She confirmed 30 days from that MDS's ARD of 9/12/25 would have been 8/11/25, and resident 7 had weighed 97 lbs.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, record review, and policy review, the provider failed to ensure medications for four of four sampled residents (18, 20, 23, and 34) with physician's orders for antifungal powder were labeled and stored according to the provider's policy. Findings include: 1. Observation in resident 23's bathroom on 12/9/25 at 10:20 a.m. revealed: *One open bottle of Miconazole 2% powder (a medicated powder used to prevent fungal growth on skin) on the shelf. The bottle had resident 23's first name and last initial handwritten on it. There was no pharmacy label on that bottle. *The bathroom is shared between four residents. 2. Observation and interview on 12/10/25 at 2:42 p.m. with resident 18 in her room revealed: *She had an open bottle of miconazole powder in the drawer of her nightstand. This did not have a resident name handwritten on it or a pharmacy label on it. *The CNAs put that powder on her when she used the bathroom. 3. Interview on 12/10/25 at 2:57 p.m. with CNA M revealed: *The nurses get creams and powders out of the medication room if a resident needed them. *They are typically stored in the resident's bathroom. *They had a daily huddle meeting and the CNAs were told to apply creams from the nurses in those meetings. *She tries to be proactive and would apply creams and powders to the residents to prevent moisture in the resident's skin folds. *She did not document that in the residents' MAR. *She stated that sometimes the nurses would ask the CNAs to apply topical creams and powders. Sometimes the CNAs would apply those items and then tell the nurse they applied them. 4. Interview on 12/11/25 at 4:15 p.m. with regional nurse consultant D revealed: *She agreed that having multiple bottles in the residents' shared bathroom created the potential for not using the correct individual residents' products. *She agreed that the individual that applied the medicated powder should be the individual to document it in the resident's MAR. *She stated that the nurses should not be documenting in the MAR that they gave a medication if they did not administer it or after they instructed the CNA to apply it. 5. Review of resident 18, 20, 23, and 34's EMR revealed: *The physician's order for the Miconazole 2% powder had instructions to apply to intertriginous [areas where skin rubs together and the friction creates moisture and fungal growth] areas two times per day. *Resident 18, 29, 23, and 34 did not have physician's orders to self-administer the Miconazole 2% powder. Review of the provider's January 2018 Medication Storage in the Facility policy revealed: *Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) [are] permitted access to medications. *Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and policy review, the provider failed to ensure standard infection control practices were followed by:*One of one certified nursing assistant (CNA) (L) performed hand hygiene while assisting residents during their dining experience.*One of one CNA (K) performed hand hygiene (handwashing) before putting on gloves and after removing his gloves.*One of one CNA (P) wore personal protective equipment (PPE) (such as a gown and gloves) while providing cares for a resident (4) on contact precautions (a gown and glove were to be worn anytime there was a risk of contact with a resident or objects he may have been in contact with).*Two of two CNAs (K and P) adequately cleaned and disinfected the shower room with a hospital grade disinfectant between residents' showers in two of two shower rooms. Findings include:1. Observation on 12/9/25 between 11:14 a.m. and 11:58 a.m. in the provider's dining room revealed: *Certified nurse assistant [CNA] L sat down at the dining table at 11:47 a.m. between residents 24 and 26. -She grabbed the front handrails of resident 24's wheelchair. She pulled the resident closer to the table. -She turned to resident 26 and pulled resident 26's wheelchair closer to the table. -She did not perform hand hygiene between touching both residents wheelchairs. Continued observation on 12/9/25 at 11:52 a.m. revealed: *CNA L was feeding resident 24 a bite of food. *She turned to resident 26 and provided that other resident a bite of food with the same hand. *She did not perform hand hygiene between feeding the residents with the same hand. 2. Observation on 12/11/25 at 9:52 a.m. of the 100-hall tub room revealed: *In the tub room was a spray bottle of Fabuloso 2x lavender bottle (a household cleaner) and a bottle of Medline Micro-Kill Q3 (a hospital grade disinfectant) on the shelf in the shower. -The Fabuloso was purple in color. *On the inside of the cover of the white laundry basket was a brown smear, and the interior seams of the laundry basket had a dense line of a brown substance on it. *The bucket for under the shower chair had a purple liquid in it. *The seat of the shower chair was wet. *The surrounding walls of the back portion of the shower area were dry. 3. Interview on 12/11/25 at 9:58 a.m. with CNA O revealed: (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The Fabuloso 2X was used by the night staff to clean the floor of the tub room. *She used the Micro-Kill disinfectant to spray the shower after she finished showering a resident. She let the Micro-Kill sit on the surface until just before she showered another resident when she would rinse off the surfaces of the shower. 4. Observation and interview on 12/11/25 at 10:32 a.m. with CNA J in the 300-hall shower room revealed: *There were two shower rooms in the facility in the 100 and 300 hallways. *The 100-hall tub room had a bathtub and shower in it, but the 300-hallway shower room only had a shower. *The 300-hall shower room did not get used often. *There was a bottle labeled with the Fabuloso 2X label with a clear colored cloudy liquid. *There was not a bottle of Micro-Kill in the 300-shower room. 5. Interview on 12/11/25 at 12:09 p.m. with nurse consultant D revealed: *She had spoken with the administrator about the Micro-Kill and the Fabuloso 2X. *During the day the housekeeping staff were to use the Micro-Kill to clean the shower room and then use the Fabuloso 2X after, to make the room smell better. *The Micro-Kill was to be used on the shower chair and all the surfaces in the shower as it was a hospital grade disinfectant. *The Fabuloso was left in the shower room because at night the CNAs cleaned the resident wheelchairs with it and then washed the floors of the tub room after they cleaned the wheelchairs. 6. Observation on 12/11/25 at 1:51 p.m. of CNA P as she exited the 100-hall tub room revealed: *She was not wearing a gown or gloves. *She pushed resident 4 on a bath chair, down the hallway, and into his room. *After she pushed resident 4 into his room, she exited the room and put on a gown and gloves and reentered the room. *On the outside of resident 4's room was a sign that indicated he was on contact precautions. 7. Observation and interview on 12/11/25 at 2:00 p.m. with CNA K in the 100-hall tub room revealed: *There was a pair of gloves in the trash can but no gown. *Resident 4's medicated shampoo and a bottle of Baby Magic Wash labeled stock were on the half (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wall that divided the shower and the rest of the room. -The bottles had water droplets on them. *CNA K pushed the shower chair that was used by resident 4 into the tub room. *He was not wearing a gown or gloves when he entered the tub room. *He applied gloves without having performed hand hygiene. *He removed the bucket from under the shower chair, sprayed the shower chair with Fabuloso 2X and then rinsed it off with water. *Sprayed the shower chair with Micro-Kill and then rinsed it off with water. *He did not spray the surrounding walls or floor of the shower with either the Fabuloso or the Micro-Kill. *CNA K confirmed the shower chair was the one used by resident 4. *He picked up a blanket that had been lying on the tub and placed it in the hamper. *He removed his gloves and did not perform hand hygiene. *He stated the bucket under the shower chair was cleaned with Fabuloso spray and then sprayed with Micro-Kill. He would let the Micro-Kill sit for a little while to dry and if it was not dry, he would dry it off before it was used for another resident. *CNA K did not know if either the Fabuloso or the Micro-Kill had a contact time (the specific duration cleaning/disinfecting product must remain visibly wet on a surface to effectively kill germs, clean, or achieve its intended chemical action). *He picked up the bottle of resident 4's shampoo and the Baby Magic Wash and placed it in a cabinet beside other bottles of shampoos and body washes without cleaning the outside of the bottles. *CNA K exited the tub room and returned with resident 37 to give him a shower. 8. Interview on 12/11/25 at 2:13 p.m. with CNA P revealed: *To clean the shower, she sprayed the purple-colored cleanser on the shower chair and floor and let it sit for a couple minutes and then rinsed it off. *She stated the purple-colored cleaner had a three-minute contact time. *She did not know if the Micro-Kill had a contact time. *She verified she had not worn a gown while she showered resident 4. *She was aware she was supposed to wear a gown and gloves for resident 4's cares because he was (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on contact precautions. 9. Interview on 12/11/25 at 4:04 p.m. with nurse consultant D revealed: *She would expect all staff to perform hand hygiene per policy. This included when their hands or gloves were soiled, when switching between a dirty procedure and a clean procedure, between glove changes, after assisting one resident and before assisting another resident, and when assisting residents with eating. *She expected PPE to be worn while providing cares if a resident was on EBP or contact precautions. *She expected the tub and shower be cleaned with proper disinfectant between each resident's use. *She verified resident 4's medicated shampoo and the stock bottle of Baby Magic Wash should have been cleaned prior to placing them back in the cabinet because there was the potential for those bottles to have been contaminated with touch or splash due to the proximity to the location in which the resident would have sat while he took a shower. 10. Review of the providers May 2025 Hand Hygiene policy revealed: *Hand hygiene refers to a general term that applied to hand washing, antiseptic handwash, and ABHR [alcohol based hand rub]. *Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions. before and after eating or handling food. *The preferred methos of hand hygiene is with ABHR for the following situations: -Before and after direct contact with residents -After contact with the resident's intact skin -After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident. Review of the provider's 1/26/25 Transmission Based Precautions policy revealed: *Facility will use contact precautions in addition to standard precautions for residents known or suspected to have a serious illness easily transmitted by direct resident contact or by contact with items in the resident's environment. *Hand hygiene should be completed prior to donning [putting on] and after removal of gloves. *Gloves should be worn when entering the room and while providing care for the resident. *Gloves should be changes when contaminated (e.g. handling fecal material and wound drainage). *Gloves should be removed before leaving the resident's room and hand hygiene should be performed immediately. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*After glove removal and hand hygiene, hands should not touch potentially contaminated environmental surfaces or items. *A gown should be donned prior to entering the room or resident's cubicle. *The gown should be removed before leaving the resident's room. *TRANSPORTATION FOR MEDICALLY NECESSARY REASONS: -When the resident leaves the room, precautions should be maintained to minimize the risk of transmission of pathogens to others and contamination of surfaces or equipment. Review of the provider's 2/25/25 Cleaning and Disinfection of Equipment policy revealed: *Cleaning refers to removal of visible soil (e.g., organic and inorganic material) from objects and surfaces and is normally accomplished manually or mechanically using water with detergents or enzymatic products. *Disinfection: refers to thermal or chemical destruction of pathogenic and other types of microorganisms. *Device classification Noncritical (touches intact skin but not mucous membranes). *Devices (examples) Stethoscopes, tabletops, bedpans, etc. *Spaulding process classification Low-level disinfection. *Hospital disinfectant with label claim for HBV [hepatitis B virus] and HIV [human immunodeficiency virus]. Review of the 2022 Medline Micro-Kill Q3 manufacturer's instructions revealed: *Micro-Kill Q3 is a concentrated one-step disinfectant formulated for general hospital cleaning and the disinfection of hard, nonporous, non-food surfaces. *Three-minute contact time for many bacteria and viruses. Review of the Fabuloso manufacturer's information indicted it was a household cleaner that killed most viruses and bacteria but was not considered a hospital grade disinfectant because it was not indicated to kill HBV or HIV.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the provider failed to ensure the code status (emergent treatment a person wishes to receive if their heart or breathing would stop) for three of three sampled residents (1, 23, and 37) was currently and accurately documented in the residents' electronic medical records. Findings include: 1. Interview on [DATE] at 2:54 p.m. with resident 37 revealed: *The staff had spoken with him when he was admitted about his wishes if his heart were to stop (advanced directives or code status). *He told them he wanted a do not resuscitate (DNR) (no cardiopulmonary resuscitation [CPR] or other heroic measures would be started if his heart or breathing stopped) code status. Review of resident 37's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *His Brief Interview of Mental Status (BIMS) assessment score was 14, which indicated his cognition was intact. *The advanced directives area in the EMR banner (a resident information area on the EMR screen) was blank. *His physician's orders did not include his advanced directives wishes. *His [DATE] admission progress note did not indicate what his resuscitation wishes were. *His EMR documentation did not include his DNR wishes. *His [DATE] care plan indicated on [DATE] his wishes were to be a DNR. *His EMR included his signed advanced directives to initiate CPR, from his previous [DATE] admission to the facility. 2. Review of resident 1' EMR revealed: *He was admitted on [DATE]. *His [DATE] admission progress notes indicated he was a full code [to start CPR if his heart or respirations stop] at this time per wife *On [DATE] resident 1's representative signed a form that indicated a DNR code status. -The physician signed that form on [DATE]. *There was a [DATE] DNR physician's order. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Interview on [DATE] at 2:17 p.m. with licensed practical nurse (LPN) I revealed: *A resident's code status could be found under the miscellaneous tab in the resident's EMR, and on the EMR banner. Residents with full code statuses were to have a red dot near their door. *Residents usually were admitted from the hospital with a physician's order that indicated their code status. *Residents are to be asked upon admission what their code status wishes were. *The resident's code status would be updated on the EMR banner by the nurses or medical records person once the order was received from the physician. *If the code status was not documented in the physician orders or on the EMR banner, it could be in the admission progress notes. 4. Interview on [DATE] at 4:27 p.m. with regional nurse consultant D revealed: *The resident's advanced directive was to be entered onto the resident's EMR banner and the physician's orders immediately upon admission to the facility. *She explained she would not wait for a physician's signature on the resident's advanced directive before entering them into the resident's EMR, because the advanced directives were to be based on a resident's wishes not the formality of a physician signature. *She agreed that the time lapse between the resident representative's designating resident 1 as a DNR code status and the physician's signature had the potential for resident 1's advanced directive wishes to not have been followed. *She verified that resident 37 did not have his current advanced directives in his EMR or on his EMR banner. 5. Review of resident 23's EMR revealed: *She was admitted to the facility on [DATE] from the hospital. *Her hospital discharge paperwork included resuscitation status: full resuscitation [fullc code]. *Her EMR banner stated, Advance Directives: DNR [do not resuscitate]. *There was no signed document in her EMR that stated her code status wishes. *Social services director/interim administrator C completed her admission assessments on [DATE]. The note stated DNR code status remains. *Resident 23 confirmed wishes to be DNR status on [DATE]. 6. Interview on [DATE] at 11:10 a.m. with LPN [licensed practical nurse] H revealed: (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*The facility does not use paper charts. All documents are uploaded to the resident's electronic chart. 7. Interview on [DATE] at 9:29 a.m. with certified nursing assistant (CNA) T revealed: *A resident had a full code status if they had a red dot next to their name on the sign by the door to their room. *The staff could also look at the banner in the resident's EMR to quickly see their code status. 8. Interview on [DATE] at 2:55 p.m. with LPN I revealed: *The nurses were to ask the resident their code status wishes when the resident admitted to the facility. *The signed form was to be sent to medical records staff to scan into the resident's EMR. *The EMR banner was to be updated with the resident's code status by the nurses. *The nurses were to document the resident's choice is for code status in the admission progress note. 9. Interview on [DATE] at 3:13 p.m. with registered nurse (RN)/ minimum data set (MDS) coordinator E revealed: *When a resident admitted to the facility, social services director/interim administrator C was responsible for speaking with the resident about their code status wishes, putting their choice in the resident's care plan, and sending the document to the provider to sign. *Social services director/interim administrator C was not available for interview at the time of the survey. 10. Interview on [DATE] at 7:56 a.m. with regional nurse consultant D revealed that she could not find any signed document in resident 23's EMR regarding her code status. 11. Further interview on [DATE] at 4:38 p.m. with regional nurse consultant D revealed: *She expected the resident's code status to be updated on admission to the facility. *She expected the EMR code status banner and the physician's order to be accurate. *She agreed that the resident's wishes should be updated regardless of having a physician's signature on the document. *She agreed that there was a risk for not following the resident's wishes if the code status was not updated immediately. 12. Review of the provider's [DATE] Advanced Directives policy revealed that: *Each resident was to choose their advance directives on admission. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*An advance directive form shall be completed with the resident and/or legal representative to verify treatment options as well as code status. *If the resident is unable or chooses not to initiate any type of advance directive, it is the policy of this facility for the resident to be a full code and to receive appropriate life sustaining treatment interventions such as CPR. *The resident's choice of code status will be added to the physician order sheet. *The resident's advance directive and treatment options/refusals will be documented in the medical record, as well as, care planned during the admission process.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure their policy was followed for: *Medication administration documentation for four of four sampled residents (18, 20, 23, and 34) with physician's orders for antifungal powder according to the provider's policy. *Implemented for one of one resident (5) who had physician-ordered speech services. Findings include: 1. Observation in resident 23's bathroom on 12/9/25 at 10:20 a.m. revealed: *One open bottle of Miconazole 2% powder (a medicated powder used to prevent fungal growth on skin) on the shelf. The bottle had resident 23's first name and last initial handwritten on it. There was no pharmacy label on that bottle. *This bathroom was shared between 4 residents. 2. Observation and interview on 12/10/25 at 2:42 p.m. with resident 18 in her room revealed: *She had an open bottle of miconazole powder in the drawer of her nightstand. This did not have a resident name handwritten on it or a pharmacy label on it. *The CNA's would put that powder on her when she used the bathroom. 3. Interview on 12/10/25 at 2:57 p.m. with CNA M revealed: *The nurses get creams and powders out of the medication room if a resident needed them. *They had a daily huddle meeting and the CNA's were told to apply creams from the nurses in those meetings. *She tried to be proactive and would apply creams and powders to the residents to prevent moisture in the resident's skin folds. *She did not document that that in the residents' medication administration records (MAR). *She stated that sometimes the nurses would ask the CNAs to apply topical creams and powders. Sometimes the CNAs will apply those items and then tell the nurse they applied them. 4. Interview on 12/11/25 at 4:15 p.m. with regional nurse consultant D revealed: *She agreed that the individual who applied the medicated powder should be the individual to document it in the resident's MAR. *She agreed that having multiple bottles in the residents' shared bathroom created the potential for not using the correct individual residents' products. *She stated that the nurses should not be documenting in the MAR that they gave a medication if they did not administer it or after they instructed a CNA to apply it. 5. Review of resident 18, 20, 23, and 34's EMR revealed: (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*The physician's order for the Miconazole 2% powder had instructions to apply to intertriginous [areas where skin rubs together and the friction creates moisture and fungal growth] areas two times per day. *Residents 18, 29, 23, and 34 did not have physician's orders to self-administer the Miconazole 2% powder. 6. Review of the provider's 5/20/22 CNA job description revealed the CNAs were expected to: *performs various tasks assigned by the floor nurse. *completes medical records documenting care provided. 7. Review of the provider's December 2019 Medication Administration & General Guidelines policy revealed: *Medications are prepared only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations to prepare and administer medications. *The person who prepares the dose for administration is the person who administers the dose. *Residents can self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications. *The individual who administers the medication dose records the administration on the resident's MAR/eMAR directly after the medication is given. 8. Observation and interview on 12/9/25 at 9:24 a.m. with resident 5 in his room revealed: *His clothes appeared to be too big for him. *He was hard of hearing and did not respond to questions. *He looked at his watch, said it was 9:30, and then stated, I don't know but think it is night. 9. Review of resident 5's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *His 10/7/25 Brief Interview of Mental Status assessment score was a 4, which indicated his cognition was severely impaired. *His diagnoses included: Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), dysphagia (difficulty or discomfort in swallowing food or liquids, potentially leading to serious complications like aspiration pneumonia), protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), and need for assistance with personal cares. *He was hospitalized from [DATE] to 4/7/25 for aspiration pneumonia (an upper respiratory (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection). *There was a 4/7/25 physician order for speech therapy services. 10. Interview on 12/10/25 at 11:36 a.m. with regional nurse consultant (RNC) D regarding resident 5's 4/7/25 physician-ordered speech therapy, revealed that there were no documented speech therapy evaluations or treatments for resident 5. 11. Follow-up interview on 12/10/2025 at 1:50 p.m. with RNC D regarding resident 5's 4/7/25 physician-ordered speech therapy revealed that she had visited with the provider's therapy department, and resident 5 had not received speech therapy services. 12. Review of the provider's 11/18/25 Following Physician Orders revealed All physician orders should be followed as written. The prescriber should be contacted if any order is not clear/understood. The physician should be notified when an order is not followed for any reason (omission, medication not in stock, repeated resident refusals for medication/treatments, etc.). 13. Interview and review of the providers' above policy regarding following the physician's orders on 12/11/25 at 1:41 p.m. with RNC D revealed that the staff did not follow that policy related to resident 5's 4/7/25 physician's order for speech therapy.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the provider failed to ensure two of two sampled residents (1 and 17) who used side rails (bars attached to the bed) had documented alternatives attempted prior to the implementation of using those side rails and the risks and benefits of using those side rails were reviewed with the resident or the resident's representative. Findings include: 1. Observation and interview on 12/09/25 at 9:35 a.m. of resident 17's room revealed: *There were two quarter-length side rails in the up position at the head of her bed. *She used the side rails to change position herself in bed and to help transfer herself in and out of bed. Review of resident 17's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *Her 10/21/25 Brief Interview of Mental Status (BIMS) assessment score of 15, indicated her cognition was intact. *A 10/15/25 physician's order for, Enabler bars [side rails] in [on] both sides of [her] bed to help [her] with repositioning. *Her 10/15/25 Side rail/Other Device Evaluation assessment indicated she requested the side rail, so that she is able to reposition self [herself] and also [to] help staff. -The check box in front of the Select any/all alternatives that have been attempted was Other and within the Specify other alternative(s) Enabler bars on both sides of bed was documented as the intervention attempted prior to the installation of the side rails. -The assessment did not include if any alternatives were attempted prior to the implementation of those side rails. -Resident 17 gave consent for the installation of the side rails on 10/15/25 at 3:45 p.m. -There was no documentation of what the risks and benefits of the side were or if the risk and benefits were reviewed with resident 17 prior to her consent for the installation of the side rails. 2. Observation on 12/9/25 at 4:00 p.m. of resident 1's room revealed two quarter-length side rails in the up position at the head of his bed. Review of resident 1's EMR revealed: *He was admitted on [DATE]. *His 10/25/25 BIMS assessment score was 13, which indicated his cognition was intact. *A 10/20/25 physician's order for, Bilateral enabler bars on the bed to help with repositioning for [the] resident. *His 10/17/25 Side rail/Other Device Evaluation assessment indicated he requested the side rail, so that he is able to reposition [himself] when in bed. -The check box in front of the Select any/all alternatives that have been attempted was Other and within the Specify other alternative(s) enabler bars was documented as the intervention attempted prior to the installation of the side rails. -The assessment did not include if any alternatives were attempted prior to the implementation of the side rails. -Resident 1's resident representative gave consent for the installation of the side rail on 10/17/25 at 1:00 p.m. -There was no documentation of what the risks and benefits of the side were or if the risks and benefits were reviewed with resident 1 or his representative prior to his representative giving consent for the installation of those side rails. 3. Interview on 12/10/25 at 2:46 p.m. with licensed practical nurse (LPN) I revealed: *If a resident would request side rails, or if a staff member would think a resident would benefit from a side rail the nurse would request a physician's order for the use of a side rail. *When the physician's order for the side rail was received the nurse would complete the Side rail/Other Device Evaluation assessment. *A request would then be made for maintenance to install the side rails on the resident's bed. *The interdisciplinary team (IDT) would discuss the potential for the installation of side rails on a resident's bed and determine if there was an alternative that could be attempted before the side rails were implemented. *Therapy was involved with some residents when a side rail was requested or recommended. *Not all residents who requested a side rail or were suggested to use a side rail by a staff member, had alternatives attempted prior to the installation of the side rail. *LPN I stated the nurses would obtain consent from the resident or the resident's representative when completing the Side rail/Other Device Evaluation assessment. *She verified the resident's risks and benefits for the use of a side rail was not included in the Side rail/Other Device Evaluation assessment. 4. Interview (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 12/11/25 at 4:21 p.m. with regional nurse consultant D revealed:*The provider did not have a policy related to the side rails if the side rails were not determined to be a restraint.*She stated the resident or resident's representative would give consent for the use of the side rails and the review of the risks versus benefits of the side rails would be part of the consent process.*She did not know if the provider attempted any alternatives prior to the installation of the side rails or where that would have been documented.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and policy review, the provider failed to ensure two of two sampled residents (19 and 35), who received an altered texture therapeutic diet of pureed food, received the required nutritional value and the required amount of pureed food served to them. Findings include: 1. Observation and interview on 12/9/25 at 11:10 a.m. with cook Q revealed that pureed broccoli was prepared with water. [NAME] Q stated the cooks were trained that pureeing broccoli with water was appropriate. She reported that she often used water to puree vegetables and used broth as the liquid to puree other foods. [NAME] Q agreed that using water to puree vegetables would reduce the nutritional value of the vegetables. Observation on 12/9/25 at 11:43 a.m. of cook R in the kitchen revealed cook R dished the pureed food items by pouring the food from a pan without using a scoop to measure the amounts of those foods. Review of resident 19's electronic medical record (EMR) revealed a physician-ordered diet of puree texture. Review of resident 35's EMR revealed a physician-ordered diet of puree texture. Interview on 12/11/2025 at 12:14 p.m. with certified dietary manager (CDM) F regarding pureed food revealed:*The proper serving of pureed foods included the use of the correct-sized scoop according to what was listed on the menu spreadsheet, and pureed foods were not to be poured from a pan without measuring.*There was a color-coded instruction sheet posted in the kitchen that indicated the scoop size to be used when serving foods.*Foods were to be pureed with a liquid that contained nutritional value.-Water had no nutritional value and should not be used to puree food. Review of the provider's 2020 Pureed Food Preparation policy revealed:*Pureed foods will be prepared using standardized recipes to ensure quality, flavor, palatability, and maximum nutritive value.*Recipes will not use water to thin pureed foods. Only broth, milk, juice, gravy, margarine or another appropriate condiment that preserves flavor shall be used.*Serve with appropriate scoop number or divide equally to provide an equal number of portions. All the pureed food must be used in order to deliver the correct nutrient density to each resident. Review of the provider's 2020 Menu Diet Spreadsheets/Portion Serving Communication Tool revealed:*Diet spreadsheets are based on the planned menu and reflect serving portions for regular and therapeutic diet orders offered in the community.*Diet spreadsheets are dated for each day of the menu cycle and are reviewed and approved by the registered dietitian. Interview on 12/11/25 at 2:34 p.m. with regional nurse consultant D regarding serving of pureed food revealed:*A scoop was to be used for measuring the amount of pureed food to be provided to each resident on a therapeutic pureed diet.*Water had no nutritional value.*She confirmed the provider's policies regarding Pureed Food Preparation and Menu Diet Spreadsheets/Portion Serving Communication were not followed by cooks Q and R.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 provider failed to ensure food safety standards were followed by three of three employees (certified nursing assistant (L), guest services aide (GSA)/cook R, and cook Q), completed proper hand hygiene during one of one meal service. Findings include: Based on observation, interview, and policy review, the provider failed to ensure three of three employees (certified nursing assistant (L), guest services aide (GSA)/cook R, and cook Q), completed proper hand hygiene during one of one meal service. Findings include: 1. Observation on 12/9/25 between 11:14 a.m. and 11:58 a.m. in the provider's dining room revealed: *Resident 7 was one of the first to arrive in the dining room at 11:19 a.m. She was the second to last resident to be served lunch at 11:58 a.m. *Certified nurse assistant [CNA] L sat down at the dining table at 11:47 a.m. between residents 24 and 26. -She grabbed the front handrails of resident 24's wheelchair. She pulled the resident closer to the table. -She turned to resident 26 and pulled resident 26's wheelchair closer to the table. -She did not perform hand hygiene between touching both residents' wheelchairs. Continued observation on 12/9/25 at 11:52 a.m. revealed: *CNA L was feeding resident 24 a bite of food. *She turned to resident 26 and provided that resident a bite of food with the same hand. *She did not perform hand hygiene between feeding the residents with the same hand. 2. Review of the providers' May 2025 Hand Hygiene policy revealed: *Hand hygiene refers to a general term that applied to hand washing, antiseptic handwash, and ABHR [alcohol based hand rub]. *Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions. before and after eating or handling food. *The preferred methos of hand hygiene is with ABHR for the following situations: -Before and after direct contact with residents -After contact with the resident's intact skin (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident. 3. Observation and interview on 12/9/25 at 11:30 a.m. of meal service revealed: *Guest Services Aide (GSA)/cook R was wearing one-use gloves. -With those gloves, she served chicken teriyaki, fried rice, broccoli, and egg rolls with different utensils. -She then picked up a slice of bread with a pair of tongs and placed it on the plate next to the above food items. -With those same gloved hands, she took a lid off a pan that was in the steam table, took a cheeseburger on a bun that was wrapped in tinfoil from that pan, removed the tinfoil, picked up the cheeseburger bun with the same gloves on, and placed it on a plate. -GSC/cook R completed this routine two more times. -GSC/Cook R confirmed she had used tongs for bread, but not for the cheeseburger in a bun. *She agreed she had potentially contaminated her one-use gloves by touching utensils, tinfoil, and a pan lid before touching the cheeseburger bun. 4. Observation and interview on 12/9/25 at 11:43 a.m. with cook Q revealed: *She had on a one-use glove on one hand, there was no glove on her other hand. *She took a bag of hot dog buns, opened it with both hands, reached into the bag, and took out a hot dog bun with her gloved hand. *Cook Q confirmed she was not aware of all the locations the hotdog bun bag had been before she opened it. -She agreed she had potentially contaminated her one-use gloved hand by touching the hot dog bag, opening it with both hands, and then touching a hot dog bun with her gloved hand. 5. Review of the provider's 2020 Handwashing and Glove Use policy revealed: *Policy: Guidelines for handwashing and glove use to promote safe and sanitary conditions throughout the Food and Nutrition Services Department must be followed. *Gloves: -Gloves may be used for one task only. -It is important to remember that gloves can often give a false sense of security and can carry germs the same as our hands. 6. Interview on 12/11/2025 at 12:14 p.m. with certified dietary manager (CDM) F revealed: (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Ready-to-eat food, such as buns, should not be touched with potentially contaminated gloves or ungloved hands. *The provider's process was to use gloves for one task only. *She confirmed GSA/cook R and cook Q had not followed the provider's policy for glove use. 7. Interview on 12/11/25 at 2:34 p.m. with regional nurse consultant (RNC) D stated that she expected staff members to avoid touching food with gloved or ungloved hands that could be potentially contaminated.		