| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445293 | A. Building<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Memphis Jewish Home | 36 Bazeberry Road<br>Cordova, TN 38018 |

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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to follow physician's orders for the use of oxygen for 1 of 2 (Resident #182) sampled residents reviewed for respiratory care. The findings include: Review of the facility policy titled, Administering Medications, dated 9/2025, revealed .Medications will be administered.as prescribed by the resident's attending physician or the facility's medical director. Review of the medical record revealed Resident #182 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure, Dependence on Supplemental Oxygen, and Hypoxemia [low levels of oxygen in the blood]. Review of the quarterly Minimum Data Set assessment dated [DATE], revealed Resident #182 scored a 15 on the Brief Interview for Mental Status assessment, which indicated she was cognitively intact. Review of the Care Plan revised 9/10/2024 revealed .Administer oxygen per MD [Medical Director] orders. Review of the Physician's Orders dated 1/10/2026, revealed .7/23/2025.O2 [Oxygen] @ [at] 2 L [Liters] BNC [by nasal canula] O2 Sat [saturation] qshift [every shift] when O2 is in use Three Times A Day. Review of the Respiratory Therapy Progress Notes revealed Resident #182 was receiving oxygen therapy at 3L BNC on the following dates: a. 1/3/2026 at 11:00 AM b. 1/5/2026 at 7:35 AM c. 1/6/2026 at 11:00 AM d. 1/7/2026 at 9:20 AM e. 1/8/2026 at 1:40 PM f. 1/9/2026 at 7:30 AM g. 1/10/2026 at 11:07 AM h. 1/11/2026 at 7:14 AM i. 1/12/2026 at 10:05 AM j. 1/13/2026 at 9:40 AM h. 1/14/2026 at 1:00 PM Review of the Medication Administration Record (MAR) dated 1/2026, revealed oxygen therapy was documented as being administered at 2 L via (by way of) BNC per physician order every shift daily from 1/1/2026 to 1/31/2026. Review of the MAR dated 2/2026, revealed oxygen therapy was documented administered at 2 L via BNC per physician order every shift daily 2/1/2026 to 2/11/2026. Observation in the facility's front lobby on 2/9/2026 at 11:40 AM and 2/10/2026 at 11:05 AM, revealed Resident #182 was receiving O2 via BNC at 3L per portable tank. Observation in the resident's room on 2/9/2026 at 2:39 PM and 2/10/2026 at 3:26 PM, revealed Resident #182 was receiving O2 BNC at 3L per oxygen concentrator. Observation in the resident's room on 2/10/2026 at 8:55 AM, revealed Resident #182 was receiving O2 via BNC at 2.5 L per oxygen concentrator. During an interview on 2/11/2026 at 11:10 AM, Licensed Practical Nurse (LPN) I was asked what rate Resident #182's oxygen should be. LPN I stated, I think 3L.the order is for 2L. LPN I was asked what Resident #182's oxygen was usually administered at. LPN I stated, 2 Liters. Observation in Resident #182's room on 2/11/2026 at 12:36 PM, revealed Resident #182 was receiving O2 BNC at 3.5L per oxygen concentrator. During an interview on 2/11/2026 at 12:43 PM, the 400 Hall Unit Manager was asked what rate Resident #182's oxygen should be. The 400 Hall Unit Manager stated, 2 Liters. During an observation and interview in Resident #182's room on 2/11/2026 at 12:44 PM, the 400 Hall Unit Manager was asked what rate Resident #182's oxygen was being administered at. The 400 Hall Unit Manager stated 3.5 [liters]. During an interviewˆon 2/11/2026 at 2:22 PM, RT D was asked if she was providing Respiratory Therapy with a resident that has a physician's order for 2L what the resident's oxygen should be administered at. RT D stated, 2 Liters.we can not change their oxygen order. RT D was asked if the resident was receiving oxygen therapy at 3L but the physician's order<br>(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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was for 2L what would she do. RT D stated, Change it to 2 [liters]. ^ During an interview on 2/11/2026 at 2:53 PM, the Director of Nursing (DON) was asked to explain the process of oxygen administration. The DON stated, The orders go to their [Resident's] MAR, so the nurse should know that. The DON was asked if oxygen should be administered at the rate prescribed by the physician. The DON stated, Yes, it's a treatment order. ^ ^ |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of Diclofenac Sodium Topical (where medication is applied directly to a specific surface of the body) Gel 1% (a medication applied to the skin used to treat arthritis pain) packing insert user guide, Federal Drug Administration website, policy review, medical record review, observation, and interview, the facility failed to ensure 1 of 9 (Registered Nurse (RN) B) nurses administered medications with a medication error rate of less than 5 percent (%). A total of 2 errors were observed out of 27 opportunities, resulting in a medication error rate of 7.41%. The findings include: 1. Review of the Diclofenac Sodium Topical Gel 1% .user guide, dated 2/2022, revealed .Remove the dosing card from inside of the carton. You should always use the dosing card to measure out the correct dose of Diclofenac Sodium Topical Gel.Measuring the correct amount using the dosing card.For each upper body area.Squeeze gel from tube equal to the length shown on the upper body section of the dosing card (2.25 inches). Review of the Federal Drug Administration website (fda.gov/drugsatfda) label information for Protonix (pantoprazole) (a medication used to decrease the amount of acid produced in the stomach), dated 2009, revealed .PROTONIX Delayed- Release Tablets [tab] should be swallowed whole.PRONTONIX Delayed- Release Tablets are prepared as enteric-coated tablets so that absorption of pantoprazole begins only after the tablet leaves the stomach.should not be split, crushed, or chewed.should be swallowed whole. 2. Review of the facility policy titled, Administering Medications, dated 9/2025, revealed .Medications will be administered.as prescribed by the resident's attending physician or the facility's medical director.The individual administering the medication must ensure that the right medication, right dosage, right time and right method of administration are verified before the medication is administered. 3. Review of the medical record revealed Resident #97 was admitted to the facility on [DATE], with diagnoses including Dysphagia, Peptic Ulcer, and Primary Osteoarthritis. ˆ Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #97 scored a 5 on the Brief Interview for Mental Status (BIMS) assessment, which indicated Resident #97 was severely cognitively impaired. ˆˆ Review of the Physician Order dated 1/26/2026, revealed diclofenac sodium [OTC [over the counter] gel.1 % .topical.APPLY 2 GRAM TOPICALLY TO AFFECTED AREA THREE TIMES PERDAY. Review of the Physician Order dated 1/26/2026, revealed pantoprazole tablet, delayed release.40 mg [milligram].oral.Take 1 tab po [by mouth] twice [two times] daily before meals. ˆ Review of the Physician Order dated 1/26/2026, revealed sucralfate suspension.100 mg/ml [milliliter].oral [by mouth].Take 10ml po in the morning, at noon, in the evening, and at bedtime. ˆ Observation during medication administration on 2/10/2026 at 4:34 PM, revealed RN B removed the following medications from the medication cart to administer to Resident #97. a. diclofenac sodium gel 1%. b. pantoprazole 40mg delayed release 1 tablet. c. sucralfate suspension 100mg/ml 10 ml RN B crushed the pantoprazole 40mg delayed release tablet and mixed it with pudding, poured 10ml of sucralfate suspension 100mg/ml into a medicine cup, removed the diclofenac sodium 1% gel from its box and squeezed 10ml from the tube into a medicine cup, entered Resident #97's room, administered the pantoprazole delayed release and the sucralfate suspension to the resident by mouth. Resident #97 was assessed for pain and voiced pain in left shoulder. RN B removed the 10 ml of diclofenac sodium 1% gel from medicine cup and applied it to Resident #97's left shoulder. RN B crushed a delayed release medication and failed to use the manufacturers supplied dosing card to measure and administer an accurate dosage of a topical medication, resulting in administration errors for both medications. During an interview on 2/10/2026 at 4:48 PM, RN B was asked if 10 ml of diclofenac sodium 1% gel was equivalent to the ordered 2 grams. RN B stated, Honestly I usually put about 10 ml in this cup. RN B was asked if that could result in a dosage other than the prescribed 2 gram. RN B stated, Yeah. RN B was asked if delayed release medications should be crushed. RN B stated, Probably no, but if she is an aspiration risk they can. She has difficulty swallowing. During an<br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | interview on 2/11/2026 at 12:07 PM, the Director of Nursing (DON) was asked if staff should follow the Physician's Order when administering medications. The DON stated Yes. The DON was asked if an order is to apply 2 gram of a topical gel, and the box includes a dosage card that has directions to apply 2.25 inches to obtain the prescribed dosage, and the nurse instead administered 10ml of the medication, would that give the required dosage of that medication. The DON stated, No. The DON was asked if that could result in a dosage greater than or less than the ordered dose. The DON stated, It could. The DON was asked if staff should crush delayed release medication. The DON stated, No. The DON was asked if crushing a delayed release medication can alter the effectiveness and absorption of the medication. The DON stated, It can. ˆ |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, the Centers of Disease Control Guideline for Disinfection and Sterilization in Healthcare Facilities review, Centers for Disease Control and Prevention Enhanced Barrier Precautions sign, medical record review, observation, and interview, the facility failed to ensure proper infection control practices were followed when 4 of 11 staff (Licensed Practical Nurse (LPN) A and I, Treatment Nurse J, and Certified Nursing Assistant (CNA) K) failed to wear Personal Protective Equipment (PPE) for Transmission Based (Isolation) Precautions (TBP) and Enhanced Barrier Precautions, failed to follow infection control standards for the use of reusable equipment, and failed to perform hand hygiene for 4 of 14 (Resident #6, #116, #175, and #179) sampled residents. The findings include: 1. Review of the facility policy titled Administering Medications, dated 9/2025, revealed .Established facility infection control procedures must be followed during the administration of medications .isolation precautions . Review of the facility policy titled Enhanced Barrier Precautions, dated 9/2025, revealed .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and gloves use during high contact resident care activities.All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions.Signs will be placed on the closet door.An order for enhanced barrier precautions will be obtained for residents with any of the following.indwelling medical devices.urinary catheters.even if the resident is not known to be infected or colonized with a MDRO.PPE [personal protective equipment] for enhanced barrier precautions is only necessary when performing high-contact care activities.Handwashing is available in all resident rooms.High-contact care activities include.Device care or use.urinary catheters.Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or.discontinuation of the indwelling medical device that placed them at high risk. Review of the facility policy titled Infection Prevention and Control Program, dated 9/2025, revealed . It is policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per national standards and guidelines.Hand Hygiene Protocol.All staff shall wash their hands.after handling contaminated objects, after PPE removal.Staff shall wash their hands before and after performing resident care procedures.Equipment Protocol.All reusable items and equipment shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment . Review of the facility policy titled Hand Hygiene/Hand-washing, dated 2025, revealed .Hand-washing/hand hygiene is considered the most important single procedure for preventing healthcare-associated infections.Hand-washing with antimicrobial soap and water is indicated and must be performed under the following conditions.After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin.After handling items potentially contaminated with blood, body fluids, or secretions. Review of the facility policy titled COVID-19 Prevention, Response and Reporting, dated 9/2025, revealed .It is the policy of this facility to ensure that appropriate interventions are implemented to prevent the spread of COVID-19 .HCP [Health Care Provider] who enter the room of a resident with suspected or confirmed SARS-CoV-2 [the pathogen that causes COVID-19] infection should adhere to standard precautions and use a .gown . 2. Review of the Centers of Disease Control Guideline for Disinfection and Sterilization in Healthcare Facilities.Recommendations for Disinfection and Sterilization in Healthcare Facilities, dated June 2024, revealed .Cleaning of Patient-Care Devices .Disinfect noncritical medical devices (e.g., blood pressure cuff) with an EPA [Environmental Protection Agency]-registered hospital disinfectant .Ensure that, at a minimum, noncritical patient-care devices are disinfected when visibly soiled and on<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | a regular basis (such as after use on each patient). Review of the undated Centers for Disease Control and Prevention sign titled Enhanced Barrier Precautions, revealed EVERYONE MUST.Clean their hands, including before entering and when leaving the room.PROVIDERS AND STAFF MUST ALSO.Wear gloves and a gown for the following High-Contact Resident Care Activities.Device care or use.urinary catheter. 3. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses including Adult Failure to Thrive, Gastrostomy Status, and Pneumonia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #6 scored a 9 on the Brief Interview for Mental Status (BIMS) assessment, which indicated he was moderately cognitively impaired. Resident #6 was assessed for the use of a feeding tube and an indwelling urinary catheter (tube inserted into the bladder to drain urine). Review of the Physician Order dated 12/30/2025, revealed Finasteride [a medication used to treat an enlarged prostate] tablet [tab] 5 mg [milligram] .TAKE ONE TAB PER PEG [percutaneous endoscopic gastrostomy] [a tube inserted through the abdomen into the stomach to deliver nutrition, fluids, and medications] ONCE DAILY . Review of the Physician Order dated 12/30/2025, revealed Eliquis [a prescription blood thinner] tablet .5 mg .TAKE ONE TAB PER PEG TWICE DAILY . Review of the Physician's Order dated 2/10/2026, revealed . Apply barrier cream to buttocks and sacrum with each brief change. Review of the Physician's Order dated 1/1/2026, revealed . Osmolite [supplemental peg tube feeding] 1.5 @ [at] 270mL [milliliter] per PEG [Percutaneous Endoscopic Gastrostomy] [a tube placed through the abdominal wall into the stomach to provide nutrition, fluids, and medications] 5x [times]/day via [by way of] bolus [feeding administered at one setting] feedings with 270mL H2O [water] flushes per PEG 5x/day. Review of the Physician's Order dated 2/2/2026, revealed . INDWELLING FOLEY CATHETER PLACED FOR URINARY RETENTION. The facility failed to have a physician's order for the use of EBP. Observation during medication administration in the 400 Hallway, on 2/11/2026 at 8:35 AM, revealed LPN I removed an Eliquis 5mg tab and a finasteride 5mg tab from the medication cart and prepared the medications for administration. LPN I entered Resident #6's room and administered the medications as ordered by way of gastrostomy tube, after verifying placement of the tube and checking for residual. LPN I failed to don a gown prior to administering medications through a gastrostomy tube. Observation at the treatment cart outside of Resident #6's room on 2/11/2026 at 9:02 AM, revealed Treatment Nurse (TN) J obtained barrier cream from the treatment cart, used hand sanitizer and donned gloves, entered the resident's room. An Enhanced Barrier Precautions sign was posted in the room that listed gloves and gown as being required by staff during High Contact Resident Care Activities. TN J adjusted catheter tubing at the catheter drainage port, rolled the resident over, opened the incontinent brief, removed her gloves, washed her hands, and exited the room to get additional gloves from her treatment cart. TN J washed her hands, donned gloves, entered the resident's room, applied barrier cream to Resident #6's sacrum, fastened the brief, removed her gloves, and washed her hands. TN J failed to wear a gown while providing direct resident care. During an interview on 2/11/2026 at 9:11 AM, TN J was asked if Personal Protective Equipment (PPE) should be worn when providing care to residents in EBP. TN J stated, He doesn't have a wound. TN J was asked if resident had a foley catheter and peg tube. TN J stated, Yes. I probably should have worn PPE. I wasn't thinking about that since he did not have an open wound. During an interview on 2/11/2026 12:08 PM, the Director of Nursing (DON) was asked what is the purpose of EBP. The DON stated, To prevent the spread of multidrug resistant organisms. The DON was asked what determines the use of EBP. The DON replied, For example, indwelling foleys or wounds, peg tube. The DON was asked what PPE was required for EBP. The DON stated, A gown and gloves. The DON was asked if there should be a physician's order for EBP for residents that require it. The DON stated, We don't use orders we just use what their diagnoses are and our policies. The DON was asked if staff failed to wear the appropriate PPE could that potentially create an infection risk for the residents. The DON stated, Yes. 3. Review of the medical record revealed Resident #116 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction (type of Stroke), (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Dysuria (pain, burning, or discomfort during urination), and Acute Kidney Failure. ˆˆ Review of the Physician's Orders dated 12/2/2025, revealed .INDWELLING FOLEY CATHETER. The facility failed to have a physician's order for the use of EBP. Review of the admission MDS assessment dated [DATE], revealed Resident #116 scored a 15 on the BIMS assessment, which indicated he was cognitively intact.ˆResident #116 had use of an indwelling urinary catheter.ˆ Observation during catheter care in Resident #116's room on 2/9/2026 at 3:03 PM, revealed CNA C was assisting Resident #116 to reposition in bed, donned a pair of gloves, retrieved a plastic urinal (a container used to urinate in), opened the catheter tube valve (plastic valve to allow the urine to drain) and drained the catheter bag into the urinal. CNA C closed the catheter tube valve, entered the bathroom and emptied the urinal into the toilet. CNA C exited the bathroom, doffed the gloves and exited the room and walked down the hallway. CNA C failed to don a gown during catheter care, failed to place a barrier underneath the catheter and urinal while emptying the catheter bag, failed to disinfect the catheter valve after closing, and failed to perform hand hygiene before and after handling the catheter bag and urinal, and after removing her gloves. During an interview on 2/9/2026 at 3:36 PM, 500 Hall Unit Manager was asked to explain the process of catheter care including emptying a catheter bag. 500 Hall Unit Manager stated, .they check the area daily.handwashing.especially if touching a drainage bag you should have gloves on. 500 Hall Unit Manager was asked if any other supplies or items was needed when emptying a catheter bag. 500 Hall Unit Manager stated, No. ˆ During an interview on 2/11/2026 at 1:41 PM, the Infection Control Preventionist (ICP) was asked when should EBP be used. The ICP stated, .indwelling medical device, caths [catheters]. The ICP was asked if they use Physician's Orders for EBP. The ICP stated, .we do not [obtain Physician's Orders] for EBP .it's not restricting for the resident . The ICP was asked to explain the process for emptying a catheter bag. The ICP stated, .[perform] hand hygiene, [don] gown and gloves, get container, barrier, place on barrier on floor below catheter bag.open the tubing to drain [urine from the catheter bag] into the container, close the valve, then clean the catheter tip with alcohol wipe and secure back onto the bag.remove gown and gloves and wash hands with soap and water. The ICP was asked when staff should wash their hands. The ICP stated Before leaving the room. The ICP was asked if staff should wear a gown when emptying a catheter bag. The ICP stated, Yes, or anytime they are touching that catheter. ˆ During an interview on 2/11/2026 at 2:53 PM, the DON was asked what PPE should staff wear during catheter care. The DON stated, Gown and gloves. 4. Review of the medical record revealed Resident #175 was admitted to the facility on [DATE], with diagnoses including 2019-nCoV (Covid-19), Emphysema, and Chronic Obstructive Pulmonary Disease. Review of the Physician Order dated 2/4/2025, revealed Resident remains in DROPLET isolation related to COVID-19. Review of the Progress Note dated 2/9/2026 at 8:15 PM, revealed Resident Covid negative remains on droplet isolation pending 2nd Covid test. Observation in Resident #175's room on 2/9/2026 at 1:00 PM, revealed CNA K entered Resident #175's room with meal tray and provided set up assistance without donning a gown. During an interview on 2/9/2026 at 1:06 PM, CNA K was asked if staff should wear a gown if going into a covid isolation room. CNA K stated, We do if performing care, I don't know if it is right, but they say we don't have to just deliver a tray. Review of the Progress Note dated 2/10/2026 at 12:37 AM, revealed Remains on droplet precautions for covid. During an interview on 2/11/2026 at 12:07 PM, the DON was asked what PPE should be worn by staff in a droplet precautions room. The DON stated, N95 mask, gown, gloves, face shield/goggles. The DON was asked if staff doesn't adhere to wearing those items, could that potentially create a risk of transmitting illness to themselves or other residents. The DON stated, It could but not in the circumstance with this patient, she did test negative on Saturday [2/7/2026]. The DON was asked if that the first test. The DON stated, Yes. The DON was asked how many negative tests are required to discontinue the isolation precautions for Covid-19 residents. The DON stated, .it requires 2 negative tests. 5. Review of the medical record revealed Resident #179 was admitted to the facility on [DATE], with diagnoses including Parkinson's, Hypertension, and Dysphagia. Review of the admission MDS assessment dated [DATE], revealed (continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #179 scored an 11 on the BIMS assessment, which indicated he was moderately cognitively impaired. Observation in Resident #179's room on 2/11/2026 at 7:01 AM, revealed LPN A knocked on the door, rolled the portable vital sign machine into room, obtained the resident's blood pressure, the pulse oximetry (ox) was not working, LPN A exited the room to obtain another pulse ox. LPN A returned to the room, obtained the resident's pulse oximetry, and exited the room pushing the portable vital machine. LPN A failed to complete hand hygiene before or after resident contact and failed to clean the reusable equipment before or after use on the resident. During an interview on 2/11/2026 at 7:25 AM, LPN A was asked if reusable equipment should be cleaned before and after use. LPN A stated, The cuff [blood pressure cuff] and pulse ox should have been cleaned. ˆDuring an interview on 2/11/2026 at 12:17 PM, the DON was asked if staff should perform hand hygiene between glove changes. The DON stated, Yes. The DON was asked if reusable medical equipment should be cleaned between uses on residents. The DON stated, Yes, we should wipe it down. |