STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445430	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lewis Park Post Acute	119 Kittrell Street Hohenwald, TN 38462

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to ensure that residents received the necessary treatment and services consistent with professional standards of practice to promote healing when the facility failed to stage a pressure wound upon discovery, perform weekly wound assessments, and when wound care treatments were not performed for 2 of 3 (Residents #6 and #79) sampled residents reviewed for pressure ulcers. The findings include: 1. Review of the facility policy titled, Pressure Injuries Overview, dated March 2024, revealed .Pressure Ulcer/Injury .refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical device .A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage . Review of the facility policy titled, Treat In Place/Advanced Nursing Protocols, dated 1/9/2025, revealed .It is the goal of the facility to provide safe, high quality care with appropriate services to all residents in the facility .The facility will provide assessment and early recognition of residents experiencing an acute change of condition and will initiate/modify the therapeutic regimen .to maximize clinical and functional outcomes. The facility will follow Treat in Place Protocols .to provide more timely treatment, to improve outcomes . Review of the undated facility policy titled, Steps A Nurse Will Take When a New Wound is Identified, revealed .Nurse will complete documentation/evaluation. Provider and RP [Responsible Party] notification. Treatment order will be entered [in the] EMR [Electronic Medical Record]. 2. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses including Quadriplegia, Chronic Pain Syndrome, Pressure Ulcer Right Buttocks, Schizophrenia, Abnormal Weight loss, Open Wound Scrotum/Testes, and Retention Urine. a. Review of the medical record revealed Resident #6 developed a facility acquired pressure ulcer on the right buttock on 10/22/2024. Review of the Wound Assessment sheet dated 10/22/2024, revealed .Assessment Date .10/22/2024 .Date Wound Identified .10/22/2024 .Source of Wound .Facility Acquired .Location of Wound .Buttock .Right .Wound Type .Pressure Stage .BLANK .Partial Thickness .Length .1.60cm x [by] Width .1.00cm x [depth] 0.1cm . Review of the Wound Assessment sheet dated 10/28/2024, revealed .Location of Wound .Buttock .Right .Pressure Stage .BLANK .Partial Thickness .Length .0.5cm x 1.30cm x 0.1cm . Review of the Wound Assessment sheet dated 11/4/2024, revealed .Location of Wound .Buttock .Right Pressure Stage .BLANK .Thickness .Partial Thickness .Exudate .Small .Exudate Type .Serosanguineous [clear blood tinged fluid] Surrounding Tissue .Abnormal .Erythema [redness of the skin] .Length .2.50cm x Width .1.50cm x Depth .0.1cm Wound Progression .Declined . Review of the Wound Assessment sheet dated 11/11/2024, revealed .Wound Identified .10/22/2024 .Location of Wound .Buttocks Right .Pressure Stage .Stage 3 Full Thickness .Exudate .Moderate .Type .Serosanguineous .3.0cm x 2.0cm x 0.2cm .Wound Note .Decline, Type change in wound . The facility failed to document the stage of the right buttock wound that was found on 10/22/2024 when identified and when it began to decline on 11/4/2024, until 11/11/2024 when it was staged as a Stage 3. b. Review of the medical record revealed Resident #6 developed a facility acquired pressure ulcer behind the left knee on 8/11/2025. Review of the Wound Evaluation sheet for Resident #6 dated 8/11/2025, revealed .Other .Body Location .Left Popliteal Fossa-Medial and (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Proximal [behind the left knee-area closest to the middle of the body and area closest to the body core] .New .Age Unknown .Acquired .In House .Area .2.14cm x Length .2.21cm x Width .1.32cm x Deepest Point .0.2cm .Type .Other .Other specify .Suspected Pressure .Staged by .N/A [not applicable] .% [percentage] Slough [non-viable tissue that is yellow tan] .80% .Exudate .Moderate .Type .Serosanguineous .Open area to posterior lower left leg, wound bed contains moderate amount of slough . The sheet was electronically signed by the Director of Nursing (DON). The facility failed to document the stage of the Left Popliteal Fossa-Medial and Proximal pressure ulcer that was identified on 8/11/2025 with 80% of the wound bed that was covered in slough, until 7 days later. Review of the Care Plan dated 8/12/2025, revealed .Alteration in musculoskeletal status r/t [related to] Quadriplegia [paralyzed arms and legs and unable to move] .Resident [#6] has stage 2 pressure ulcer to left medial thigh and is at risk for further breakdown and/or slow delayed healing .date initiated 8/18/2025 .Resident has an Unstageable pressure ulcer to left posterior thigh and is at risk for further breakdown and or slow delayed healing related to decreased mobility .initiated 8/18/2024 .Right ischium [right buttock] stage 3 pressure ulcer .11/22/24 [2024] unstageable [pressure ulcer where you cannot see the wound bed or depth due to the presence of slough (thick white or green color tissue covering the wound bed) or eschar (thick dark brown or black tissue covering the wound bed)]. 11/27/24 stage 4 pressure ulcer [stage of a pressure wound where the bone, muscle or tendons are exposed]. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #6 was cognitively intact. Resident #6 had upper and lower body impairment in all extremities, used a wheelchair for mobility, and was dependent on staff for Activities of Daily Living skills. Resident #6 had an external catheter and was incontinent of bowel. Diagnoses included Non-Traumatic Spinal Cord Dysfunction, Quadriplegia, Pressure Ulcer Right Buttocks, and unhealed pressure ulcers, Stage 2 and Stage 4. c. Review of the medical record revealed Resident #6 developed a facility acquired pressure ulcer of the rear left thigh. Review of the Wound Evaluation sheet for Resident #6 dated 8/18/2025, revealed .Pressure .Unstageable .(Slough and/or eschar) .Body Location .Rear Left Thigh .Stable .7 days old .Acquired .In-House .1.63cm x 2.18cm x 1.3cm x 0.2cm .Type .Pressure .Stage .Unstageable .Due to .Slough and/or eschar .Rear Left Thigh .% Slough .100% . During an interview on 8/20/2025 at 6:05 PM, the DON confirmed Resident #6's pressure wounds to his Right Ischium (buttocks) that was identified on 10/22/2024 and Left Leg that was identified on 8/11/2025 were not staged when they were identified and confirmed that when the wound care nurse is not present in the building to assess resident wounds that the Nurse Practitioner or any other Registered Nurse can assess and stage wounds upon identification. 3. Review of the medical record revealed Resident #79 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Pneumonia, Heart Failure, Diabetes, and Depression. Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #79 was cognitively intact. Resident had 2 unstageable pressure ulcers present on admission. Review of the Physician's Order dated 8/8/2025, revealed Right rear thigh: Cleanse with NS [Normal Saline], pat dry with gauze. Apply xeroform [used to promote wound healing] to wound bed, cover with super absorbent silicone dressing every day shift AND as needed for change for spoilage [soilage] or displacement of dressing. Review of the Physician's Order dated 8/8/2025, revealed Abdominal fold: cleanse with NS, pat dry with gauze. Apply calcium alginate [used for wounds with moderate to heavy drainage] to wound bed, cover with silicone foam dressing every day shift every 2 day(s) for Altered Skin Integrity AND as needed for soiled or displaced dressing. Review of medical record revealed Resident #79 was admitted to the hospital on [DATE] and returned to the facility on 8/14/2025. Review of the Physician's Order dated 8/15/2025, revealed Right rear thigh: Cleanse with NS, pat dry with gauze. Apply xeroform to wound bed, cover with super absorbent silicone dressing .every day shift . Review of the Physician's Order dated 8/15/2025, revealed Abdominal fold: cleanse with NS, pat dry with gauze. Apply calcium alginate to wound bed, cover with silicone foam dressing .every day shift . Review of the Treatment (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administration Record dated 8/2025, revealed wound care treatment was not provided on 8/14/2025 and 8/15/2025. The facility failed to follow physician's orders for wound care when treatments were not provided on 8/14/2025 and 8/15/2025. Review of the Skin and Wound Evaluation dated 8/18/2025, revealed Resident #79 had the following wounds: a. a pressure ulcer stage 3 (full thickness skin loss) to the left lower quadrant of the abdomen with measurements of length 5.3cm x width 5.8 cm x depth 0.2 cm with moderate serosanguineous drainage, and surrounding tissue with erythema (redness of the skin). b. a pressure ulcer stage 3 to the rear right proximal thigh with measurements of length 3.2 cm x width 1.7 cm x depth 0.2 cm, with moderate serosanguineous drainage and surrounding tissue with erythema. c. a pressure ulcer stage 3 to the rear right distal (outer portion) thigh with measurements of length 2.4 cm x width 2.3 cm x depth 0.2 cm with moderate serosanguineous drainage and surrounding tissue with erythema. During an interview on 8/20/2025 at 6:05 PM, the Director of Nursing (DON) confirmed Resident #79 returned to the facility on 8/14/2025 and a Skin and Wound Evaluation was not performed until 8/18/2025. The DON confirmed that wound care was not performed on Resident #79 on 8/14/2025 and 8/15/2025 and staff should follow physician's orders. The DON confirmed residents' wounds should be assessed and evaluated when they return to the facility. The DON confirmed that wounds should be assessed and staged immediately when identified to prevent the delay in care and to ensure proper treatment is put into place for healing. The DON confirmed that staff failed to stage pressure ulcers.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, resident trust accounts review, medical record review, and interview, the facility failed to refund the resident's funds within 30 days of death or discharge for 1 of 2 (Resident #78) sampled residents reviewed for personal trust fund account. The findings include: Review of the undated facility policy titled, .Resident Trust Fund . revealed .Upon death or discharge of a resident with a personal fund account, the facility will convey within 30 days the resident's funds and a final accounting of those funds .to the individual or probate jurisdiction administering the resident's estate . Review of the medical record revealed Resident #78 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Malnutrition, Dysphagia, and Anxiety. Review of Resident #78's Trust Fund Statement dated 4/1/2025 through 6/25/2025, revealed Resident #78 had an account balance of $70.08. Review of the Nurse's Note dated 6/8/2025, revealed .Pronouncement of death at 6:10 AM . The facility failed to provide documentation that the resident's estate had been reimbursed within 30 days of the resident's death. During an interview on 8/19/2025 at 2:39 PM, the Business Office Manager confirmed the facility had not refunded Resident #78's account balance to the individual or resident's estate. The Business Office Manager confirmed that the balance should be refunded within 30 days of discharge or death.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the Resident Assessment Instrument (RAI) User's Manual review, medical record review, and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were signed by a Registered Nurse for 7 of 18 (Resident #1, #6, #13, #23, #31, #40, and #73) sampled residents reviewed. The findings include: 1. Review of the Minimum Data Set (MDS) Resident Assessment Instrument (RAI) User's Manual dated 2023, revealed .RNAC [Registered Nurse Assessment Coordinator] An individual licensed as a registered nurse by the State Board of Nursing and employed by a nursing facility and is responsible for coordinating and certifying completion of the resident assessment instrument . 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Diabetes, Anxiety, and Depression. Review of the quarterly MDS assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #1 was cognitively intact. The MDS section Z0500 was electronically signed for accuracy by Licensed Practical Nurse (LPN) B. 3. Review of the medical record revealed the Resident #6 was admitted to the facility on [DATE], with diagnoses including Quadriplegia, Post Traumatic Stress Disorder, and Schizophrenia. Review of the quarterly MDS dated [DATE], revealed a BIMS score of 15, which indicated Resident #6 was cognitively intact. The MDS section Z0500 was electronically signed for accuracy by LPN B. Review of the annual MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #6 was cognitively intact. The MDS section Z0500 was electronically signed for accuracy by LPN B. 4. Review of the medical record revealed Resident #13 was admitted to the facility on [DATE], with diagnoses including Depressive Disorder, Hypertension, and Anxiety. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 9, which indicated Resident #13 was cognitively intact. The MDS section Z0500 was electronically signed for accuracy by LPN B. 5. Review of the medical record revealed Resident #23 was admitted to the facility on [DATE], with diagnoses including Femur Fracture, Diabetes, Anxiety, and Urinary Tract Infection. Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #23 was cognitively intact. The MDS section Z0500 was electronically signed for accuracy by LPN B. 6. Review of the medical record revealed Resident #31 was admitted to the facility on [DATE], with diagnoses including Cerebral Infraction, Diabetes, and Hypertension. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 00, which indicated Resident #31 was severely cognitively impaired. The MDS section Z0500 was electronically signed for accuracy by LPN B. 7. Review of the medical record revealed Resident #40 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Anxiety, Depression, and Dementia. Review of the admission MDS dated [DATE], revealed a BIMS score of 00, which indicated Resident #40, was severely cognitively impaired. The MDS section Z0500 was electronically signed for accuracy by LPN B. Review of the quarterly MDS dated [DATE], revealed a BIMS score of 00, which indicated Resident #40 was severely cognitively impaired. The MDS section Z0500 was electronically signed for accuracy by LPN B. 8. Review of the medical record revealed Resident #73 was admitted to the facility on [DATE], with diagnoses including Anxiety, Depression, and Chronic Kidney Disease. Review of the admission MDS assessment dated [DATE], revealed a BIMS score 14, which indicated Resident #73 was cognitively intact. The MDS section Z0500 was electronically signed for accuracy by LPN B. During an interview on 8/19/2025 at 10:51 AM, the MDS Coordinator confirmed that all MDS assessments should be signed by a Registered Nurse for accuracy.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, and interview, the facility failed to ensure monitoring was conducted according to the physician's order for 1 of 5 (Resident #31) sampled residents reviewed for unnecessary medications. The findings include: Review of the facility policy titled, Administering Medications, dated 4/2019, revealed .Medications are administered in a safe .manner as prescribed.Medications are administered in accordance with prescriber orders.The following information is checked/verified for each resident prior to administering medications.vital signs if necessary. Review of the medical record revealed Resident #31 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Diabetes, and Hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #31 was severely cognitively impaired. Resident #31 had a diagnosis of Hypertension. Review of the Physician's Order dated 2/24/2025, revealed Resident #31 had an order for Losartan Potassium (medication used for high blood pressure) 50 milligrams (mg) to give by mouth one time a day and to hold the medication when the systolic (the top number of the blood pressure) blood pressure (BP) results were less than 110. Review of the Medication Administration Record (MAR) dated 7/2025, revealed there were no blood pressure results from 7/29/2025 to 7/31/2025. Review of the MAR dated 8/2025, revealed there were no BP results documented from 8/1/2025 to 8/19/2025. Review of the Weights and Vitals Summary sheet revealed there were no BP results documented during the timeframe of the administration of Losartan on the following dates: a. from 7/29/2025 to 7/31/2025 b. from 8/1/2025 to 8/4/2025 c. from 8/6/2025 to 8/8/2025 d. from 8/10/2025 to 8/16/2025 e. 8/18/2025. During an interview on 8/19/2025 at 3:43 PM, the Director of Nursing confirmed that a blood pressure should be checked and documented prior to giving an antihypertensive medication when there are guidelines ordered to hold the antihypertensive medication for specific parameters.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to ensure the prevention and spread of infection when 1 of 17 staff (Certified Nursing Assistant (CNA) C) failed to use appropriate Personal Protective Equipment (PPE) during dining for 2 of 2 (Resident #25 and #33) sampled residents in transmission based precautions (TBP) and when 2 of 17 staff (CNA E and CNA F) failed to perform hand hygiene for 2 of 18 (Resident #6 and #40) residents observed for dining in the dining room. The findings include: 1. Review of the facility policy titled , Handwashing/Hand Hygiene, dated 10/2023, revealed .This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.Hand hygiene is indicated.immediately before touching a resident.after touching a resident.after touching the resident's environment.Single-use disposable gloves should be used.when in contact with a resident, or the equipment or environment of a resident, who is on contact precautions. Review of the facility policy titled, Isolation-Categories of Transmission-Base Precautions, dated 9/2024, revealed .Transmission-based precautions are initiated when a resident develops sign and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents.Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected.Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment.Staff and visitors wear gloves (clean, non-sterile) when entering the room.Staff and visitors wear a disposable gown upon entering the room. 2. Review of the medical record revealed Resident #6 was admitted to the facility 8/23/2024, with diagnoses including Quadriplegia, Post Traumatic Stress Disorder, Chronic Pain Syndrome, Pressure Ulcer Right Buttocks, Schizophrenia, and Dysphagia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status score (BIMS) score of 15, which indicated Resident #6 was cognitively intact, and was dependent on staff for eating. Observation during dining in the dining room on 8/18/2025 at 12:10 PM, revealed CNA E assisted Resident #6 with his meal. CNA E cut up the pulled chicken sandwich with a knife and picked up a piece of the sandwich with her bare hands and placed it into the resident's mouth. Resident #6 chewed and swallowed the bite and CNA E proceeded to pick up another piece of the sandwich with her bare hands and placed it into Resident #6's mouth multiple times. CNA E failed to perform hand hygiene and/or apply gloves while assisting Resident #6 with his meal and before picking up the food with her bare hands. 3. Review of the signage posted outside Resident #25 and #33's room titled, Contact Precautions, revealed, .Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. 4. Review of the medical record revealed Resident #25 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Anxiety, and Hypertension. Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #25 was cognitively intact. Review of the Physician's Order dated 8/19/2025, revealed .Contact precautions r/t [related to] VRE [Vancomycin-Resistant Enterococci, bacteria that developed resistance to the antibiotic Vancomycin]. Observation during dining in Resident #25's room on 8/19/2025 at 5:38 PM, revealed CNA C entered the resident's room without donning PPE gown or gloves, and provided setup assistance with the meal tray. 5. Review of the medical record revealed Resident #33 was admitted to the facility on [DATE], with diagnoses including Bacteremia (presence of live bacteria in the bloodstream), and Sepsis (life-threatening complication of an infection). Review of the Physician's Order dated 8/7/2025, revealed .Contact isolation due to E.coli [Escherichia coli, a type of bacteria (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that normally lives in the intestines of humans] and ESBL [extended-spectrum beta-lactamase, enzymes made by some bacteria that break down certain antibiotics] in urine. Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 11, which indicated Resident #33 was moderately cognitively impaired. Observation during dining in Resident #33's room on 8/19/2025 at 5:35 PM, revealed CNA C entered the resident's room without donning PPE gown or gloves, and provided setup assistance with meal tray. 6. Review of the medical record revealed Resident #40 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Anxiety, Claustrophobia, and Depression. Review of the quarterly MDS assessment dated [DATE], revealed staff were unable to perform a BIMS due to Resident #40 was severely cognitively impaired and required supervision assistance of staff with eating. Observation during dining in the dining room on 8/18/2025 at 12:35 PM, revealed CNA F cut up the pulled chicken sandwich for Resident #40, picked up a piece of the sandwich with her bare hands and handed it to Resident #40. CNA F failed to perform hand hygiene, and/or apply gloves, before picking up the resident's food with her bare hands. During an interview on 8/20/2025 at 11:05 AM, the Director of Nursing (DON) confirmed that staff should not pick up resident's food with their bare hands. During an interview on 8/20/2025 at 2:52 PM, the Assistant Director of Nursing (ADON) confirmed staff should use appropriate PPE when entering a contact isolation room and failure to do so could result in potential cross contamination.

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, Centers for Medicare & Medicaid Services guidelines, Infection Prevention Control Officer Training certificate review, and interview, the facility failed to ensure employment of a qualified Infection Control Preventionist to monitor and maintain the facility's Infection Prevention and Control Program. This could have affected 71 out of 71 residents residing in the facility. The findings include: 1. Review of the facility policy titled, Infection Prevention and Control Program, dated 12/2023, revealed .An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.The IPCP is coordinated and overseen by an infection prevention specialist (infection preventionist). 2. Review of the Centers for Medicare & Medicaid Services factsheet titled, Updated Guidance for Nursing Home Resident Health and Safety, dated [DATE], revealed .Requires facilities have a part-time Infection Preventionist (IP) .The IP must physically work onsite and cannot be an off-site consultant or work at a separate location .IP role is critical to mitigating infectious diseases through an effective infection prevention and control program .IP specialized Training is required and available . 3. Review of the IP's Training Certificate revealed an expiration date of [DATE]. During an interview on [DATE] at 2:52 PM, the IP confirmed that the IP training certificate had expired.