STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525353	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stevens Point Health Services	1800 Sherman Ave Stevens Point, WI 54481

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure 2 residents (R) (R3 and R34) of 5 sampled residents had documentation that indicated the residents or their legal representatives were informed in advance of the risks and benefits of prescribed medications. R3 was prescribed divalproex sodium (Depakote) (an anticonvulsant medication) and clindamycin phosphate external solution 1% topical (an antibiotic medication). Verbal consent for the medications was received from R3's activated Power of Attorney for Healthcare (POAHC), however, written consent was not obtained.R34 was prescribed Ambien (a sedative medication), quetiapine (an antipsychotic medication), hydroxyzine (an antihistamine medication used to treat anxiety), Lyrica (an anticonvulsant medication used to treat neuropathic pain), Lexapro (an antidepressant medication), and oxcarbazepine (an anticonvulsant medication used to treat bipolar disorder). The facility did not obtain consents for the psychotropic medications.Findings include:1.On 7/21/25, Surveyor reviewed R3's medical record. R3 was most recently admitted to the facility on [DATE] and had diagnoses including dementia, cognitive communication deficit, stroke, diabetes, seizures, and depression. R3's Minimum Data Set (MDS) assessment, dated 7/12/25, had a Brief Interview for Mental Status (BIMS) score of 8 out of 15 which indicated R3 had moderately impaired cognition. R3 had an activated POAHC for healthcare decisions.R3's medical record contained the following orders: ~ Divalproex sodium (Depakote) tablet delayed release 125 milligrams (mg), give 1 tablet by mouth three times daily for seizures (dated 1/26/25).~ Buspirone HCL (Buspar) oral tablet 5 mg, give 1 tablet three times daily for depression (dated 12/24/24).~ Clindamycin phosphate external solution 1% topical, apply to underarms, breasts, groin topically in the morning for rash (dated 12/23/24).R3's medical record contained verbal consents (dated 6/4/25) for Depakote, buspar, and clindamycin that were not signed by R3's POAHC.2. On 7/21/25, Surveyor reviewed R34's medical record. R34 was most recently admitted to the facility on [DATE] and had diagnoses including diabetes, bipolar disorder, depression, anxiety, insomnia, and low back pain. R34's MDS assessment, dated 5/27/25, had a BIMS score of 15 out of 15 which indicated R34 had intact cognition. R34 made R34's own healthcare decisions. R34's medical record contained the following orders: ~ Quetiapine fumarate oral tablet 100 mg, give 1 tablet by mouth two times daily for bipolar disorder.~ Hydroxyzine HCL oral tablet 50 mg, give 1 tablet by mouth every 6 hours as needed for anxiety disorder (dated 6/4/25).~ Ambien oral tablet 10 mg, give 10 mg by mouth once daily for insomnia (dated 2/19/25).~ Lyrica (pregabalin) oral capsule 200 mg, give 1 capsule by mouth three times daily for neuropathic pain (dated 9/18/24).~ Lexapro (escitalopram oxalate) oral tablet 20 mg, give 1 tablet by mouth once daily for depression (dated 6/18/24).~ Oxcarbazepine oral tablet 150 mg, give 1 tablet by mouth once daily and give 2 tablets by mouth once daily for bipolar disorder (dated 1/8/24).On 7/23/25 at 3:31 PM, Surveyor interviewed Nursing Home Administrator (NHA)-A who indicated signed medication consents should have been obtained for R3 and R34.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not monitor for adverse consequences or the effectiveness of psychotropic medication for 1 resident (R) (R44) of 6 sampled residents. The facility did not monitor for adverse consequences or the effectiveness of trazadone (an antidepressant medication) and sertraline (an antidepressant medication) for R44. Findings include:The facility's Medication Monitoring: Medication Management policy, dated 1/2025, indicates: Each resident's drug regimen is reviewed to ensure it is free from unnecessary drugs .The facility's medication management supports and promotes .The monitoring of medications for efficacy and adverse consequences .Additional specific guidelines are applied to psychotropic drugs which are defined as any drug that affects brain activities associated with mental processes and behavior. This includes, but are not limited to antipsychotics; antidepressants .The intent of this requirement is that: Each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being .On 7/21/25, Surveyor reviewed R44's medical record. R44 was admitted to the facility on [DATE] and had diagnoses including urinary tract infection (UTI), chronic respiratory failure, chronic obstructive pulmonary disease (COPD), encephalopathy, anxiety, and insomnia. R44 had an activated Power of Attorney for Healthcare (POAHC) who made medical decisions for R44. A Minimum Data Set (MDS) assessment was not completed for R44. An admission nursing progress note indicated R44 was alert to self. On 7/21/25 at 2:53 PM, Surveyor reviewed R44's Medication Administration Record (MAR) and Treatment Administration Record (TAR) and noted R44 was prescribed sertraline HCL 100 milligrams (mg) once daily for anxiety on 7/19/25. R44 was also prescribed trazadone HCL 100 mg at bedtime for sleep on 7/17/25. R44's medical record did not contain monitoring for the efficacy or adverse consequences of sertraline, including sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremors, agitation, headache, skin rash, photosensitivity of skin, excess weight gain, and anxiousness. R44's medical record also did not contain monitoring for the efficacy or adverse consequences of trazadone, including sedation, drowsiness, dry mouth. blurred vision, urinary retention, tachycardia, muscle tremors, agitation, headache, skin rash, photosensitivity of skin, excess weight gain, and sleeplessness.On 7/22/25 at 1:05 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated R44 should have been monitored for medication efficacy and adverse consequences of the antidepressant medications. DON-B indicated DON-B added adverse consequence monitoring to R44's TAR for nurses to initial after completing. DON-B indicated medication monitoring including effectiveness should have been added to R44's baseline care plan.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interview and record review, the facility did not implement policies and procedures that prohibit and prevent abuse for 1 (Registered Nurse (RN)-I) of 8 facility and contracted staff reviewed for caregiver background checks.The facility did not ensure a thorough and timely caregiver background check was completed for agency RN-I.Findings include:The facility's Abuse, Neglect and Exploitation policy, revised 7/15/22, indicates: Potential employees will be screened for history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants. Background checks, including re-checks, will be completed consistent with applicable state laws and regulation .On 7/22/25 at 1:59 PM, Surveyor reviewed background check information for 8 facility and agency staff, including RN-I. Surveyor noted RN-I's Background Information Disclosure (BID) form was not dated. RN-I's start date at the facility was 7/7/25.On 7/22/25 at 2:25 PM, Surveyor interviewed Business Office Manager (BOM)-J who indicated RN-I's agency may have sent the facility an incorrect BID form. BOM-J indicated BOM-J would review the file that was sent to the facility to see if there was a dated BID form for RN-I.On 7/22/25 at 4:12 PM, Surveyor interviewed BOM-J who indicated BOM-J did not notice that RN-I's BID for was not dated and should have followed up with the agency prior to RN-I's start date. BOM-J indicated BOM-J called RN-I's agency who sent RN-I's BID form with an effective date of 7/22/25.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure the State Long-Term Care Ombudsman was notified of transfers or discharges for 4 residents (R) (R41, R43, R5, and R6) of 4 sampled residents.R41 was transferred to the hospital on 7/1/25. The Ombudsman was not notified of the transfer.R43 was discharged home on 5/2/25. The Ombudsman was not notified of the discharge.R5 was transferred to the hospital on 5/9/25. The Ombudsman was not notified of the transfer.R6 was transferred to the hospital on 1/29/25, 3/17/25, and 6/15/25. The Ombudsman was not notified of the transfers.Findings include: The facility's Transfer and Discharge policy, dated 7/15/22, indicates: The facility permits each resident to remain in the facility, and not transfer or discharge the resident except as initiated by the resident, necessary for the health and safety of the resident .6. Non-Emergency Transfers or Discharges .B. At least 30 days before the resident is transferred or discharged , the Social Services Director or designee will notify the resident and resident representative in writing (notice) .d. A copy of the notice shall be provided to a representative of the Office of the State Long-Term Care Ombudsman .Emergency Transfers/Discharges .a. Obtain physician orders for emergency transfer or discharge .The physician shall document medical reasons for the transfer or discharge in the medical record .K. Social Services Director or designee shall provide notice of transfer to a representative of the State Long-Term Care Ombudsman via a monthly list . 1. On 7/23/25, Surveyor reviewed R41’s medical record. R41 was admitted to the facility on [DATE] and had diagnoses including displaced transverse fracture of shaft of humerus, dysphagia, weakness, diabetes, and multiple myeloma not having achieved remission. R41 made R41's own medical decisions. R41's Minimum Data Set (MDS) assessment, dated 6/21/25, had a Brief Interview for Mental Status (BIMS) score of 15 of 15 which indicated R41 had intact cognition. R41’s medical record indicated R41 was transferred to the hospital for evaluation on 7/1/25. 2. On 7/23/25, Surveyor reviewed R43’s medical record. R43 was admitted to the facility on [DATE] and had diagnoses including esophagitis, cognitive communication deficit, and chronic obstructive pulmonary disease (COPD). R43 had an activated Power of Attorney for Healthcare (POAHC) who made medical decisions for R43. R43's MDS assessment, dated 5/2/25, had a BIMS score of 11 out of 15 which indicated R43 had moderately impaired cognition. R43’s medical record indicated R43 discharged home from the facility on 5/2/25. 3. On 7/23/25, Surveyor reviewed R5's medical record. R5 was admitted to the facility in 2024 and had diagnoses including type 2 diabetes mellitus with long-term insulin use, non-pressure chronic ulcer to left thigh and part of right lower leg with fat layer exposure, chronic obstructive pulmonary disease (COPD), lymphedema, anxiety disorder, pressure ulcer of left buttock stage 3, and chronic respiratory failure with hypoxia. R5's MDS assessment, dated 5/28/25, had a BIMS score of 15 out of 15 which indicated R5 had intact cognition. R5’s medical recorded indicated R5 was transferred to the hospital on 5/9/25 for a change of condition related to shortness of breath. R5 returned to the facility on 5/15/25. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 7/21/25, Surveyor reviewed R6's medical record. R6 was most recently admitted to the facility on [DATE] and had diagnoses including bullous pemphigoid (an autoimmune skin disease causing blisters), COPD, malignant neoplasm of peritoneum, liver, ovary, gallbladder and bile ducts, anxiety, and schizophrenia. R6's MDS assessment, dated 6/25/25, had a BIMS score of 14 out of 15 which indicated R6 had intact cognition. R6 made R6's own healthcare decisions. On 1/29/25, R6 had a change in condition and was transferred to the hospital and diagnosed with septic shock from UTI or skin etiology. R6 was readmitted to the facility on [DATE]. On 3/17/25, R6 was transferred to the hospital and diagnosed with sepsis/Escherichia (E). coli bacteremia in setting of UTI. R6 was readmitted to the facility on [DATE]. On 6/15/25, R6 was transferred to the hospital and diagnosed with urosepsis. R6 returned to the facility on 6/23/25. On 7/23/25 at 10:42 AM, Surveyor requested the facility's monthly Ombudsman reporting list. Nursing Home Administrator (NHA)-A indicated the facility had not reported any transfers or discharges to Ombudsman (OMB)-E. NHA-A provided documentation of education with Social Services Director (SSD)-D for reporting transfers and discharges to OMB-E in a monthly report. The education was signed by SSD-D and dated 7/21/25. NHA-A provided a copy of an email NHA-A sent to OMB-E that contained a list of the facility's transfers and discharges since January 2025.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not ensure the comprehensive plan of care was revised in a timely manner for 1 resident (R) (R6) of 1 sampled resident.R6's care plan was not revised after R6 was readmitted from the hospital on 3/20/25 and 6/23/25 with diagnoses of sepsis/urosepsis (urinary tract infection (UTI) that spreads to the blood stream).Findings include: On 7/23/25, Surveyor reviewed R6's medical record. R6 had diagnoses including urosepsis, bullous pemphigoid (an autoimmune skin disease that causes blisters), chronic obstructive pulmonary disease (COPD), malignant neoplasm of peritoneum, liver, ovary, gallbladder and bile ducts, UTIs, schizophrenia, and anxiety. R6's Minimum Data Set (MDS) assessment, dated 6/25/25, had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R6 had intact cognition. R6 made R6's own healthcare decisions.On 3/17/25, R6 was transferred to the hospital and diagnosed with sepsis/Escherichia (E). coli bacteremia (presence of bacteria in the blood) in the setting of UTI. R6 was readmitted to the facility on [DATE].On 6/15/25, R6 was transferred to the hospital and diagnosed with urosepsis. R6 returned to the facility on 6/23/25.On 7/23/25 at 5:15 PM, Nursing Home Administrator (NHA)-A provided Surveyor with a copy of R6's care plan and indicated there were areas in the care plan where monitoring for signs and symptoms of UTI were indicated, however, Surveyor noted the monitoring interventions were resolved. Surveyor noted R6's care plan was not revised after R6 was hospitalized on [DATE] and 6/15/25 for sepsis/urosepsis/UTI and returned to the facility on 3/20/25 and 6/23/25. R6's care plan contained a focus area that indicated actual infection UTI (initiated on 2/4/25 and resolved on 2/11/25). The goal indicated R6 would have no further complications related to infection and intervention. The care plan contained interventions to report to physician worsening signs and symptoms of infection or lack of improvement (initiated on 2/5/25 and resolved on 2/11/25). The care plan also contained a focus area that indicated R6 had a catheter (initiated on 3/13/24 and revised on 6/23/25), however, all interventions were resolved on 2/19/25.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, staff and resident interview, and record review, the facility did not provide the necessary respiratory care and services for 1 resident (R) (R5) of 3 sampled residents. R5's continuous positive airway pressure (CPAP) and oxygen equipment were not cleaned and replaced in accordance with orders on R5's Treatment Administration Record (TAR). Findings include:The facility follows guidelines from Company (CP)-L which were provided to Surveyor on 7/23/25 at 11:06 AM by Nursing Home Administration (NHA)-A when Surveyor requested the facility's oxygen policy. The undated CP-L guidelines indicate for infection control and to reduce the risk of infections, it is important to keep your equipment clean. Care of your cannula/mask, tubing, and humidifier bottle: 1. (CP-L) recommends you replace your cannula or mask each week and oxygen extension tubing and humidifier bottle once every month. 3. The humidifier bottle must be cleaned between fills or once per week .CP-L guidelines labeled Cleaning your CPAP/Bilevel positive airway pressure (BiPAP) equipment indicate: Daily cleaning: 2. Wipe the portion of the mask that comes in contact with your skin with a damp cloth .3. Empty any remaining water from the humidifier chamber. 4. Fill the chamber with soapy water and shake vigorously. 5. Rinse the chamber with clean water. 6. Air dry. Weekly mask and tubing cleaning is recommended: 1. Hand wash the headgear in standard laundry detergent .2. Air dry headgear .3. Wash mask/nasal pillows and tubing in a mixture of warm water and a small amount of liquid dishwashing detergent or baby shampoo. Do not use detergents containing conditioners, moisturizers, or antibacterial additives .4. Rinse thoroughly. 5. Air dry. Filter Maintenance: Filter maintenance will depend on the model of CPAP/B-Level unit you use. Please review manufacturer's manual for your unit's specific maintenance recommendations. On 7/21/25, Surveyor reviewed R5's medical record. R5 was admitted to the facility in 2024 and had diagnoses including type 2 diabetes mellitus with long term insulin use, non-pressure chronic ulcer to left thigh and part of right lower leg with fat layer exposure, chronic obstructive pulmonary disease (COPD), lymphedema, anxiety disorder, chronic pain syndrome, pressure ulcer of left buttock stage 3, and chronic respiratory failure with hypoxia. R5's Minimum Data Set (MDS) assessment, dated 5/28/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 had intact cognition. On 7/21/25 at 11:15 AM, Surveyor interviewed R5 and noted a CPAP and oxygen concentrator in R5's room. R5 indicated the respiratory equipment had not been cleaned in 2 years. Surveyor reviewed R5's TAR which contained the following orders: ~ Change CPAP water chamber one time a day every 6 month(s) starting on the 1st for 1 day(s) related to chronic obstructive pulmonary disease and chronic respiratory failure (active 11/10/25). ~ Change (BiPAP/CPAP) filter every 6 months every day shift every 6 month(s) starting on the 5th for 1 day(s) for monitoring related to chronic obstructive pulmonary disease and chronic respiratory failure (active 6/5/25).~ Supplemental oxygen at 3 liters per minute (LPM) into CPAP device settings - 8.0-20.0 centimeters of mercury (cmHg) water every morning and at bedtime related to chronic obstructive pulmonary disease and chronic respiratory failure. On at bedtime and off in morning and as needed related to chronic obstructive pulmonary disease and chronic respiratory failure. Encourage use during naps (active 5/18/25).~ Clean CPAP machine wash with gentle soap and water, rinse thoroughly, and air dry one time a day every Saturday related to chronic obstructive pulmonary disease and chronic respiratory failure (active 5/24/25). ~ Change oxygen tubing and humidifier bottles weekly. Date tubing one time a day every Sunday and as needed for visibly soiled or known contamination (active 4/6/25). ~ CP-L to manage settings and provide supplies as needed to include mask and headgear, cushion, filters, tubing and water chamber. No directions specified for order (active 6/1/25). R5's May 2025 TAR indicated:~ The oxygen tubing was not changed on 5/30/25.~ The oxygen tubing and humidifier bottles were not changed on 5/11/25 and 5/30/25.~ Clean CPAP machine wash with gentle soap and water, rinse thoroughly, and air dry was not completed on 5/10/25, 5/17/25, and 5/18/25.~ Change nebulizer tubing every nightshift every Monday and Sunday was not completed on 5/19/25.~ Change nebulizer tubing once a day every Monday and Sunday was not completed on 5/11/25 and 5/12/25.R5's June 2025 TAR indicated: ~ Change CPAP filter every 6 months was not completed on 6/5/25.~ Clean CPAP machine wash in gentle soap and water, rinse thoroughly, and air dry was not completed on 6/14/25. R5's July 2025 TAR indicated: ~ Clean CPAP machine wash in gentle soap and water. rinse thoroughly, and air dry was not completed on 7/12/25.~ Oxygen at 3 LPM connected to CPAP device was not completed on 7/9/25, 7/12/25, and 7/18/25. ~ Check oxygen saturation every shift was not completed on 7/9/25, 7/12/25, and 7/18/25.On 7/23/25 at 11:12 AM, Surveyor interviewed Licensed Practical Nurse (LPN)-F who indicated LPN-F did not clean respiratory

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not ensure accurate order transcription and medication administration for 1 resident (R) (R5) of 2 sampled residents.On 7/22/25, R5 was administered 81 milligram (mg) of enteric coated (EC) aspirin which differed from R5's order. In addition, the wrong dose of fluticasone propionate was administered. Findings include:On 7/22/25, Surveyor reviewed R5's medical record. R5 was admitted to the facility on [DATE] and had diagnoses including diabetes and heart failure. R5's Minimum Data Set (MDS) assessment, dated 5/29/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 had intact cognition. On 7/22/25 at 8:04 AM, Surveyor observed Registered Nurse (RN)-K administer R5's AM medication. RN-K administered 81 mg of EC aspirin and 2 sprays of fluticasone propionate nasal spray in each nostril. Surveyor reviewed R5's physician orders which indicated:~ Aspirin 81 mg capsule, give one capsule daily~ Fluticasone propionate, one spray in each nostril On 7/22/25 at 1:19 PM, Surveyor interviewed RN-K who was unsure why R5's aspirin order was transcribed in capsule form. RN-K was aware that the order indicated capsule form but stated the facility did not have aspirin in capsule form. RN-K and Surveyor reviewed R5's hospital discharge summary which contained an order for aspirin 81 EC tablet. RN-K verified the order was incorrectly transcribed and stated RN-K would fix the order in R5's MAR.On 7/22/25 at 1:23 PM, RN-K confirmed R5's fluticasone propionate order was for 1 spray in each nostril and confirmed R5 was incorrectly administered 2 sprays in each nostril.On 7/22/25 at 2:09 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated DON-B had not seen aspirin in capsule form and verified the aspirin administered to R5 was not in the form that was ordered. DON-B also indicated R5's fluticasone propionate should have been administered as 1 spray in each nostril.On 7/22/25 at 2:28 PM, DON-B approached Surveyor and indicated DON-B spoke with the pharmacy who indicated EC and chewable aspirin can be interchanged and aspirin does not come in capsule form. DON-B agreed R5's aspirin order was transcribed incorrectly as a capsule instead of a tablet.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the transmission of communicable disease and infection for 1 resident (R) (R5) of 4 residents observed during the provision of cares. R5 was on enhanced barrier precautions (EBP). On 7/21/25, staff did not follow EBP during high-contact cares for R5. Finding include:The facility's Transmission-Based (Isolation) Precautions (TBP) policy, revised 9/24/24, indicates: . 10. Contact precautions: A. Intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or the resident's environment .C. Healthcare personnel caring for residents on contact precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. D. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination .F. Contact precautions will be used for residents infected or colonized with multidrug-resistant organisms (MDROs) in the following situations: i. When a resident has wound secretions or excretions that are unable to covered or contained, and ii. On units or in facilities where, despite attempts to control the spread of MDROs, ongoing transmission is occurring. On 7/21/25, Surveyor reviewed R5's medical record. R5 was admitted to the facility in 2024 and had diagnoses including type 2 diabetes mellitus with long-term insulin use, non-pressure chronic ulcer to left thigh and part of right lower leg with fat layer exposure, chronic obstructive pulmonary disease (COPD), lymphedema, anxiety disorder, chronic pain syndrome, pressure ulcer of left buttock stage 3, and chronic respiratory failure with hypoxia. R5's Minimum Data Set (MDS) assessment, dated 5/28/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R5 had intact cognition. R5's care plan and Kardex (an abbreviated care plan used by nursing staff) indicated R5 was on EBP. The care plan indicated R5 was at risk for infection related to colonization of an MDRO and had methicillin-resistant Staphylococcus aureus (MRSA) to the nares/wound. The care plan contained an intervention to use EBP during high-contact care activities. R5's Kardex indicated: Staff should follow EBP during high-contact care activities; Toileting assist of one - EBP; Clean peri-area with each incontinence episode - EBP wear gown and gloves with direct patient care; Toileting - uses bedside commode for bowel movements - EBP wear gown and gloves with direct patient care; and precautions wear gown and gloves with direct care.On 7/21/25 at 10:10 AM, Surveyor was waiting outside R39's room to interview R39 when Certified Nursing Assistant (CNA)-G indicated to R39 that CNA-G is told to wear blue gowns but will not put them on. Surveyor noted a sign outside R39's room that indicated R39 was on EBP.On 7/21/25 at 11:18 AM, Surveyor knocked on R5's door and attempted to interview R5. CNA-G indicated CNA-G was providing cares. Surveyor noted CNA-G was not wearing a gown while completing peri-care. A sign posted outside R5's door indicated R5 was on EBP. When CNA-G saw Surveyor, CNA-G indicated cares were halted because CNA-G needed to don a gown. After cares were completed, Surveyor interviewed CNA-G who confirmed CNA-G should have donned a gown at the start of cares because R5 was on EBP. On 7/21/25 at approximately 12:00 PM, Surveyor interviewed Infection Preventionist (IP)-H who indicated staff should follow a resident's precautions and don a gown and gloves during high-contact cares.On 7/22/25, Surveyor requested the facility's EBP policy but received the facility's TBP policy. When Surveyor asked Nursing Home Administrator (NHA)-A if the facility had an EBP policy, NHA-A indicated the facility did not have an EBP policy.