STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525387	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dove Healthcare - West Eau Claire	1405 Truax Blvd Eau Claire, WI 54703

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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 - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48793 Based on observation, interview and record review, the facility did not ensure that 1 of 3 residents (R) reviewed for pressure injuries (PI) received care consistent with professional standards of practice to prevent at risk of skin breakdown from occurring (R267). R267 was at risk for PI development. The facility failed to provide adequate and consistent repositioning as care planned. Findings include: Surveyor reviewed policy titled, Turning and repositioning, dated September 2024, last reviewed in October 2024, states in part: . #1. All residents at risk of, or with existing pressure injuries, will be turned and repositioned. #3. A routine schedule includes using both side-lying and back positions, alternating from the right, back, and left side. A resident's condition will determine whether a specialized turn schedule is warranted. #6. Repositioning techniques in bed: h. Ensure that heels are floated off the surface of the bed with pillows or devices designed to do so. If using heel protector, the heel must still be floated . R267 was admitted to the facility on [DATE] with diagnoses including, in part, acute and chronic respiratory failure with hypoxia, coronary artery disease, heart failure, diabetes mellitus, peripheral vascular disease, and end stage renal disease. R267's Minimum Data Set (MDS) assessment, dated 03/14/25, identified R267 required assistance for bed mobility, taking on and off footwear, rolling left to right, sit to lying, chair to bed, toileting, and for transfers. MDS also indicated that R267 was determined to be at risk for PIs. Surveyor reviewed R267's care plan: -2 assist with full mechanical lift. Non ambulatory. (continued on next page)

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 - Few	-Air mattress with safety edges bolster system, level 3 pump setting. -Float heels. -Reposition 1 assist. -Evaluate repositioning needs and individualized as needed. -Assist with repositioning as CNA care plan reflects. Surveyor reviewed R267's Braden scale: -On 03/13/25, Braden scale assessment completed with score of 14 indicating that R267 was at a moderate risk of skin breakdown. On 03/18/25 at 10:32 AM, Surveyor observed R267 lying in bed, supine with heels lying flat on the bed. Surveyor observed Podus boots lying on wheelchair. Surveyor did not observe Podus boots on R267 or R267's heels elevated to off load pressure. On 03/18/25 at 1:47 PM, Surveyor observed R267 lying in bed, supine with heels lying flat on the bed. Surveyor observed Podus boots lying on wheelchair. Surveyor did not observe Podus boots on R267 or R267's heels elevated to off load pressure. On 03/18/25 at 4:52 PM, Surveyor observed R267 lying in bed, supine with heels lying flat on the bed. Surveyor observed Podus boots lying on wheelchair. Surveyor did not observe Podus boots on R267 or R267's heels elevated to off load pressure. On 03/19/25 at 6:41 AM, Surveyor observed R267 lying in bed supine with heels directly flat on the bed. Surveyor observed Podus boots lying in wheelchair parked at the end of R267's bed. Surveyor did not observe Podus boots on R267 or R267's heels elevated to off load pressure. On 03/19/25 at 8:42 AM, Surveyor observed R267 lying in bed supine sleeping with heels directly flat on the bed. Surveyor observed head of bed up to 90-degree angle and a breakfast tray in front of R267. Surveyor observed Podus boots lying in wheelchair parked at the end of R267's bed. Surveyor did not observe Podus boots on R267 or R267's heels elevated to off load pressure. On 03/19/25 at 8:44 AM, Surveyor interviewed Registered Nurse (RN) H and asked RN H about R267's disposition in room. RN H indicated that R267 spends most of R267's time in bed, was feeling a little anxious last night, and staff notified hospice care. Surveyor asked RN H if R267 has any skin breakdown currently. RN H indicated that R267 does not have any open areas but is at risk of skin breakdown and has an air mattress in place. On 03/19/25 at 8:48 AM, Surveyor observed RN H enter R267's room and grab breakfast tray. RN did not readjust R267's bed. Surveyor observed R267 still in 90-degree angle lying in bed with eyes closed. Surveyor observed R267's heels directly on bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/25 at 9:13 AM, Surveyor observed R267 lying in bed supine sleeping with heels directly on bed. Surveyor observed head of bed up to 90-degree angle. Surveyor observed Podus boots lying in wheelchair parked at the end of R267's bed. Surveyor did not observe Podus boots on R267 or R267's heels elevated to off load pressure. On 03/19/25 at 9:59 AM, Surveyor observed R267 lying in bed supine sleeping. Surveyor observed head of bed up to 90-degree angle. Surveyor observed Podus boots lying in wheelchair parked at the end of R267's bed. Surveyor did not observe Podus boots on R267 or R267's heels elevated to off load pressure. On 03/19/25 at 11:15 AM, Surveyor observed RN H and RN G enter R267's room. Surveyor observed RN H give morphine oral to R267 and then RN H and RN G exited R267's room. Surveyor did not observe RN G or RN H reposition R267. On 03/19/25 at 11:18 AM, Surveyor interviewed RN H and RN G and asked if RN H or RN G had been in R267's room to reposition R267. RN H indicated Surveyor would need to speak with Certified Nurse Assistant (CNA) L as RN H and RN G have not repositioned R267. RN G indicated that repositioning should be every 2 hours. Surveyor asked RN H and RN G if RNs know about how often R267's Podus boots are supposed to be on. RN G indicated that RN G is unsure. RN H reviewed R267's Electronic Health Record (EHR) and RN H indicated there was no set order for Podus boots. RN H indicated that Podus boots should be on for off-loading R267's heels. On 03/19/25 at 11:25 AM, Surveyor interviewed CNA L and asked how often is R267 supposed to be repositioned. R267 indicated that CNA L usually completes repositioning every two hours. Surveyor indicated to CNA L that Surveyor has been observing for repositioning and did not see a reposition completed for R267. CNA L indicated that CNA L went into R267's room around 10:30 AM and changed her. Surveyor indicated to CNA L that Surveyor has seen R267 in the same position supine with pressure to R267's sacrum and R267's heel directly lying on the bed. CNA L indicated that CNA L needs to go in there shortly to reposition R267 off R267's bottom. Surveyor asked CNA L if Podus boots are supposed to be on. CNA L indicated that CNA L was unsure and started to review the CNA care plan. CNA L indicated to Surveyor that CNA L thinks Podus boots should be on only at night, but night shift did not place them on last night as CNA L came on this morning and did not see Podus boots on. CNA L indicated that Podus boots have been in R267's wheelchair since CNA L came on shift. Surveyor asked CNA L if R267 can reposition self. CNA L indicated that R267 cannot reposition self and requires total assistance for repositioning. On 03/19/25 at 11:35 AM, Surveyor observed CNA L and RN G enter R267's room. Surveyor observed CNA L and RN G exit R267's room shortly after entering. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/25 at 11:43 AM, Surveyor interviewed RN G and asked what side RN G repositioned R267. RN G indicated that R267 was repositioned to the right side and a pillow placed under the left side of R267 so that R267 is off R267's bottom. Surveyor requested RN G show Surveyor R267's reposition that RN G and CNA L completed at 11:35 AM. RN G pulled R267's covers off and Surveyor noted R267's heels still touching the bed and Podus boots in wheelchair. RN G indicated that RN G should probably get a thicker pillow to off load the pressure on heels or place the Podus boots on R267. Surveyor observed R267 still lying in a slight angled supine position with pillow slightly under R267's left side. Surveyor asked RN G if the reposition that RN G and CNA L completed at 11:35 was enough to off load pressure to R267's coccyx/sacrum area and if RN G could place hand underneath R267 and feel if R267's bottom is touching the mattress. RN G placed hand underneath R267's bottom and stated, Oh yea her bottom is still touching the mattress. I will need to gather [CNA L] again and try to reposition better or get another pillow underneath her. On 03/19/25 at 11:50 AM, Surveyor interviewed Nurse Manager RN E and asked expectations for R267's Podus boots and what is the expectation for off-loading R267's heels and sacrum area. Nurse Manager RN E indicated that expectation is that R267 is repositioned roughly every 2 hours. When a resident has a decline in status as R267 did last night and Hospice will be coming in today to assess R267, then Nurse Manager RN E's expectation would be that repositioning would need to be increased due to decrease in mobility. Surveyor asked what exactly does repositioning mean to Nurse Manager RN E. Nurse Manager RN E indicated that staff are to reposition and alternate from side to side lying for example left side to back then to right side then to back and so forth. Surveyor indicated to Nurse Manager RN E that Surveyor did not observe R267 repositioned fully off R267's bottom to reduce pressure to the coccyx and sacrum area and heels directly pressed against bed. Nurse Manager RN E indicated that most residents don't want to be solely on their whole side, but expectation is for staff to try and off-load the pressure as best as possible. On 03/19/25 at 3:41 PM, Surveyor interviewed Director of Nursing (DON) B and asked what the expectation is of staff repositioning residents who are dependent on cares from staff. DON B indicated that staff need to reposition at least every 2 hours and sometimes given the resident's status that some residents are repositioned hourly per individualized needs.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30570 Based on observation, record review and interview, the facility did not provide the needed supervision and care planned approaches to prevent a fall. The facility practice had the potential to affect 1 of 5 residents (R61) reviewed for falls. Certified Nursing Assistant (CNA) C did not remain at bedside after removing R61's bedside mat and body pillow placing R61 at risk for fall and injury. This is evidenced by: Surveyor requested and received the facility policy titled Fall Prevention Program dated 8/2024. The policy in part read: Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. ~Each resident's risk factors and environmental hazards will be evaluated when developing the residents comprehensive plan of care. Surveyor reviewed R61's most recent minimum data set (MDS) which was an admission MDS dated [DATE]. The MDS indicated R61 usually understands, usually is understood with a severely impaired cognition. R61 is dependent on staff for bed mobility and transfer. R61 has impairment in range of motion of one upper extremity. R61's diagnosis included encephalopathy and unspecified disorder of psychological development. R61 experienced 2 falls since his admission resulting in no injury. R61 experiences hallucinations and has verbal and physical behaviors that interfere with his care. Surveyor reviewed R61's Fall Risk assessment dated [DATE] which noted: ~Resident is confused and sometimes tries to get out of chair or bed without help ~Resident is confused and doesn't understand own limitations ~Resident is confused and does not follow simple directions ~Resident will rise without staff assist/supervision ~Resident does not/cannot recognize own limitations and does not act appropriately ~fell in the past 30 days ~Resident was injured in fall and injuries are: fracture Surveyor reviewed R61's falls since his admission and noted R61 experienced 4 falls. Surveyor noted 3 of R61's falls were from his bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor reviewed R61's CNA Safety Precautions and noted the following: ~Bed should be kept as low to the floor as possible with floor mat on the floor on exit side ~Use pillows for positioning on exit side of bed Surveyor reviewed R61's comprehensive care plan and noted: Fall Safety: 3/18/2025: ~Bed should be kept as low to the floor as possible with floor mat on the floor on exit side ~Use pillows for positioning on exit side of bed On 3/19/25 at 6:42 AM, Surveyor observed CNA C assist R61 in bed in preparation for a shower. R61 was observed in bed with bed at CNA C's waist height. CNA C removed R61's floor mat that was in front of R61's bed and placed it against a chair across the room. CNA C removed R61's blankets, positioning pillow and brief. CNA C offered R61 a urinal and left bedside to gather a bag from R61's bathroom. CNA C returned to bedside and took R61's urinal to the bathroom to empty, again leaving R61's bedside. CNA C rolled R61 side to side in bed to remove wet linens from his bed. CNA C walked from R61's bed to his closet and offered R61 clothing options. Surveyor observed R61 roll toward the front of his bed, where there was no mat. Surveyor asked CNA C if R61 has fallen in the past. CNA C responded R61 has fallen from bed, and that is why the body pillow is in place with floor mat and low bed. Surveyor noted the body pillow had been removed, and the floor mat was against a chair across the room. CNA C cued R61 to stay on his back as she walked away from bedside to return to R61's closet for a clean brief. CNA C stated to R61, You're gonna fall right off the bed if you keep doing that, we don't want that to happen, as she walked to R61's room door and looked into the hallway. CNA C returned to bedside and expressed, One day his whole legs were hanging off the end of the bed. R61 again tried rolling toward CNA C who was at bedside. CNA C walked from bedside back to R61's room door, and R61 was observed moving around the bed. CNA C returned to bedside and R61 rolled to wall and back to his back. CNA C walked from R61's bedside to outside his room to obtain a hoyer lift. CNA C returned to R61's bed to hook up a hoyer sling. CNA C and another CNA transferred R61 to a shower chair and preceded to the shower room. On 3/19/25 at 10:16 AM, Surveyor spoke with CNA C about the observation. CNA C expressed she probably should not have walked away from R61's bed due to his fall risk or have R61's interventions in place if leaving bedside. On 3/19/25 at 9:59 AM, Surveyor spoke with Nursing Home Administrator (NHA) A and Director of Nursing (DON) B about the observation. DON B expressed she would expect fall interventions to be in place if staff are not at R61's bedside. DON B further expressed it is important as R61 has tried to self transfer from bed and is at risk for falling specifically from bed. DON indicated staff should gather supplies and remain at bedside to supervise R61 in bed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 48793 Based on observation, interview and policy review, the facility did not ensure all drugs and biologicals were stored and labeled in accordance with currently accepted professional principles, did not ensure only authorized personnel had access to medications for 3 of 3 random observations. -One observation was made of resident (R) medications left on top of the medication cart when the cart was unattended and out of view of staff. (R37) -Observation of prescribed Nystatin powder left unattended in R14's room during 2 observations Findings include: Surveyor reviewed policy titled, Preparation and General Guidelines, dated May 2018, states in part: . A. The following equipment and supplies are acquired and maintained by the facility for the proper storage, preparation, and administration of medications: 1. Lockable medication carts, cabinets, drawers, and/or rooms with well-lit medication preparation areas . Example 1 On 03/18/25 at 4:21 PM, Surveyor observed an unlocked medication cart down 2300 hall. Surveyor observed no staff members in sight. Surveyor observed the unsupervised and unlocked medication cart to have two pop packs labeled with R37's name and the medication Famotidine with pills still in the pop packs sitting on top of the medication cart. On 03/18/25 at 4:31 PM, Surveyor observed different staff walk by the medication cart down the hallway. On 03/18/25 at 4:34 PM, Surveyor walked down hallway and around the corner to approach Licensed Practical Nurse (LPN) J. Surveyor interviewed LPN J and asked why medication cart is unlocked and why there are medications on top of medication without being supervised. LPN J indicated that LPN J meant to take Famotidine medication to the medication storage room but did not yet. LPN stated, I will go do this now. Surveyor asked LPN J if LPN J could even see LPN J's medication cart down the hallway. LPN J indicated that LPN J could not see the medication cart from where LPN J was sitting in the lounge. Example 2 On 03/18/25 at 11:52 AM, Surveyor observed Nystatin powder left on bedside table in R14's room. R14 was sitting in room watching TV in wheelchair. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 3 On 03/19/25 at 9:19 AM, Surveyor observed Certified Nurse Assistant (CNA) K bring Eucerin cream and prescribed Nystatin powder down the hallway into R14's room. Surveyor observed CNA K place medications in the left top drawer. Surveyor interviewed CNA K and asked what CNA K was doing with the medications. CNA K indicated that CNA K was bringing it back from the bath house where CNA K had applied to R14. CNA K showed Surveyor R14's drawer where medications are kept. Surveyor observed the left top drawer to be not lockable. Surveyor observed a right top drawer that has a lock. Surveyor observed CNA K had placed Eucerin and prescribed Nystatin powder in top left drawer. Surveyor asked CNA K why CNA K did not place prescribed medications in locked drawer in R14's room. CNA K indicated that only nurses have the key to the locked drawer. On 03/19/25 at 9:27 AM, Surveyor interviewed Nurse Tech (NT) M and had NT M follow Surveyor into R14's room. Surveyor requested NT M look in nonlockable drawer and explain what medications are in R14's drawer. NT M indicated there was prescribed Nystatin powder and over the counter Eucerin cream. NT M indicated the prescribed Nystatin powder should be locked in the locked drawer to the right of this left drawer. NT M unlocked right drawer and placed prescribed Nystatin powder in the lockable drawer and locked the drawer. On 03/19/25 at 9:37 AM, Surveyor interviewed Nurse Manager Registered Nurse (RN) F who manages 2300 and 2200 hall. Surveyor asked Nurse Manager RN F the expectation for locked medications in rooms. Nurse Manager RN F indicated that any prescription medications in residents' room should be always kept in locked drawer unless being used by a licensed individual.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 51095 Based on interview and record review, the facility did not designate a person to serve as the director of food and nutrition services who had completed the minimum qualification requirements for the position. This practice could potentially affect all 63 residents residing in the facility. Findings include: On 3/20/25 at 11:40 AM, Surveyor interviewed Nutritional Services Director (NSD) S, requesting verification of her qualifications. NSD S reported she completed an all day certification course. The certificate NSD S provided is from the National Registry Of Food Safety Professionals and it states NSD S has successfully satisfied the requirements for the International Food Safety Manager under both Conference for Food Protection Standards and ISO/IEC 17024 Standards. Certificate issued 11/16/21 and expiration date is 11/16/26. Surveyor asked NSD S if she had other schooling or training other than the conference certificate, NSD S reported she did not. NSD S did state the facility does have a Registered Dietician that comes to the facility a couple of times a week and is available to her daily Surveyor informed NSD S and NHA A the certificate provided does not meet requirements for a certified dietary manager.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51095 Based on observation, record review, and interview the facility did not prepare foods in a sanitary manner. Nutritional Service Aide (NSA) P did not allow the thermometer probe to air dry of alcohol prior to inserting into each of the nine food items intended to be served to residents for lunch. This had the potential to affect all 66 residents in the facilty. NSA N did not perform hand hygiene in between passing water pitchers to residents (R). This affected 10 of 10 residents observed receiving water pitchers (R48, R21, R20, R27, R22, R32, R45, R34, R60, and R269). NSA P prepared and served food to residents without proper hand hygiene and touched ready to eat foods with contaminated gloved hands. This affected 7 of 7 residents observed (R26, R267, R48, R22, R11, R6, and R268). This is evidenced by: Example 1 The facility procedure titled, Nutritional Services Procedure Appearance and Temperatures reviewed on March 2023 stated in part, 7. Temperatures will be taken by cleaning the thermometer with approved cleaning wipe, allowing cleaner to dry for 10-15 seconds, and placing the thermometer in center of food item. On 3/19/25 at 11:03 AM, Surveyor observed NSA P check temperatures of the foods being served at the second-floor kitchenette. NSA P wiped the thermometer probe with an alcohol prep pad and immediately inserted the thermometer into country fried steak. NSA P then continued to wipe the thermometer after each food item and immediately insert the thermometer into the next food item without allowing for the probe to dry after wiping it with the alcohol pad. NSA P used the same thermometer wiping with approved wipe and sticking it in next food without waiting after wiping with cleaning wipe. NSA P did this for all 9 foods she checked the temperature on. NSA P reported she has had training on checking food temperatures but does not recall having to wait after wiping the probe with alcohol prep pad. On 3/19/25 at 2:06 PM, Surveyor interviewed Nutritional Service Director (NSD) S about the expectations of checking temperatures of foods prior to serving. NSD S reported the expectation is after wiping the thermometer with approved cleaning wipe, the cleaner should be allowed to air dry for 10-15 seconds before placing into food item. Surveyor explained this did not occur with recent observation. NSD S acknowledges this has the potential to contaminate the foods served. 48793 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Example 2 Surveyor reviewed policy titled, Water Pass, dated June 2002, last reviewed in January 2023, which states in part: .#4. Sanitize hands and wear gloves for process. #5. Remove old cups from rooms and replace with [NAME] pass. a. Use one hand for clean mugs and one hand for dirty mugs or sanitize hands before leaving room. b. Place dirty mugs in bus tub away from clean mugs . On 03/18/25 at 12:59 PM, Surveyor observed NSA N deliver new water to residents on second floor. Surveyor observed NSA N grab a clean water jug and deliver water jug to R48. Surveyor observed NSA N take R48's used water jug and place used water jug on clean water cart. Surveyor did not observe NSA N sanitize hands upon exiting R48's room. NSA N then grabbed another new water jug and entered R21's room. Surveyor observed NSA N take R21's used water jug and place used water jug on clean water cart. Surveyor did not observe NSA N sanitize hands upon exiting R21's room. On 03/18/25 at 1:05 PM, Surveyor observed NSA N grab a clean water jug and deliver water jug to R20, R27, R22, and R32, and take out used contaminated water jugs and place on cart for R20, R27, R22, and R32. Surveyor did not observe NSA N sanitize hands upon exiting R20, R27, R22, and R32's rooms. On 03/18/25 at 1:08 PM, Surveyor observed NSA N grab a clean water jug and deliver water jug to R45, R34, R60, and R269, and take out used contaminated water jugs and place on cart for R45, R34, R60, and R269. Surveyor did not observe NSA N sanitize hands upon exiting R45, R34, R60, and R269's rooms. On 03/18/25 at 1:15 PM, Surveyor interviewed NSA N and asked about sanitizing hands in between passing waters to the units. NSA N indicated that NSA N was not trained that way, but NSA N stated, That makes sense and is probably more sanitary. I can start doing that if that's what I need to do. On 03/19/25 at 2:25 PM, Surveyor interviewed NSD O and asked expectation of NSA N for hand hygiene during water pass to residents. NSD O indicated that NSA N should be sanitizing hands in between passing clean water jugs and taking the contaminated old jug out of each resident's rooms. Example 3 Surveyor reviewed policy titled, Personnel Sanitation Standards, dated January 2017, last reviewed in March 2024, which states in part: . #3. Wear single use disposable gloves and use tongs when required to avoid bare hand contact with ready to eat foods. #5. Hands must be washed after removing gloves, using the restroom, after leaving storage rooms, taking out trash, etc., after touching your hair, mouth, or nose, and at any other time hands may become soiled . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/19/25 at 7:44 AM, Surveyor observed NSA P grab utensils and cook on the stove. Surveyor observed NSA P touch face and readjust mask with gloved hands. NSA P then grabbed bread out of bag with contaminated gloves and placed bread in toaster. Surveyor observed NSA P grab finished toast and add butter to the toast with contaminated gloves. NSA P then placed toast on tray and breakfast tray was delivered to R267. On 03/19/25 at 7:47 AM, Surveyor observed NSA P take glasses off and wipe down glasses with gloved hands. NSA P then doffed gloves and grabbed a clean pair of gloves. NSA P did not sanitize in between doffing contaminated gloves and donning new gloves. On 03/19/25 at 7:52 AM, Surveyor observed NSA P reach for a trash can with contaminated gloves. Surveyor observed NSA P doff contaminated gloves, throw gloves into the trash can, and then re-apply new gloves. Surveyor did not observe NSA P sanitize in between. NSA P grabbed toast once it was done cooking in toaster with contaminated gloved hands. NSA P placed butter and jelly on toast with contaminated gloved hands. NSA P then placed toast on tray and breakfast tray was delivered to R11. On 03/19/25 at 8:00 AM, Surveyor observed NSA P take contaminated gloves off, readjust face mask and then don clean gloves. Surveyor did not observe NSA P sanitize in between doffing contaminated gloves and donning new pair of gloves. Surveyor observed NSA P grab eating utensils and place on napkin on breakfast tray. Surveyor observed NSA P grab bread with contaminated gloves and place in toaster. NSA P grabbed a spatula and flipped hash browns on griddle. NSA P grabbed toast with contaminated gloves and placed on breakfast tray. NSA P then placed toast on tray and breakfast tray was delivered to R26. On 03/19/25 at 8:12 AM, Surveyor observed NSA P touch waist with gloved hands and rest right hand on waist. NSA P then grabbed cooked toast out of toaster with contaminated gloves. NSA P placed butter on toast and then laid toast on breakfast tray and tray was delivered to R6. On 03/19/25 at 8:14 AM, Surveyor observed NSA P pick up utensil for sausage patty. NSA P then used left contaminated glove hand to hold sausage patty down and used right hand to cut the sausage patty. NSA P then grabbed cooked toast out of toaster with right contaminated gloved hand and placed on breakfast tray. NSA P buttered the toast and then placed toast on tray and breakfast tray was delivered to R22. Surveyor did not observe any hand hygiene performed. On 03/19/25 at 8:18 AM, Surveyor observed NSA P grab cooked toast out of toaster with right contaminated gloved hand and place on breakfast tray. NSA P then placed toast on tray and breakfast tray was delivered to R268. Surveyor did not observe any hand hygiene being performed. On 03/19/25 at 8:25 AM, Surveyor observed NSA P grabbing silverware for R48's breakfast tray. Surveyor observed NSA P readjust glasses with gloved hands and then readjust face mask over nose. NSA P then started serving oatmeal and eggs in R48's bowl on breakfast tray. NSA P took lids and placed on top of bowls with contaminated gloved hands and breakfast tray was delivered to R48. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/19/25 at 8:37 AM, Surveyor interviewed NSA P. Surveyor asked NSA P what the expectation of hand hygiene is when prepping and serving residents their meals. NSA P indicated in between glove changes and any time gloves meet contaminated surfaces. Surveyor indicated to NSA P that Surveyor observed NSA P touching face and glasses and readjusting mask with contaminated gloves. Surveyor observed NSA P grab bread out of bag and place in toaster, then grab with contaminated gloves and butter the toast during all of prepping and serving. NSA P indicated that NSA P is supposed to use tongs to grab bread in and out of bag and toaster. On 03/19/25 at 2:25 PM, Surveyor interviewed NSD O and asked expectation of NSA P for hand hygiene during meal prep, in between glove changes, and serving of meals to residents. NSD O indicated that NSA P and all staff are to sanitize between glove changes. If gloves become contaminated with contaminated surfaces or personal contaminated surfaces to doff gloves, wash or sanitize in between then don new pair of clean gloves.

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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. 48793 Based on observation, interview and record review, the facility did not 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. This affected 3 of 33 (R) residents reviewed for infection control (R20, R23, R61). -Observation of LPN I not disinfecting bedside table and wound supplies during wound care dressing for R20. -Improper hand hygiene was observed during wound care and personal care for R20, R23, and R61. Findings include: Example 1 On 03/18/25 at 3:29 PM, Surveyor observed Licensed Practical Nurse (LPN) I enter R20's room and start prepping for completing R20's wound dressing change on coccyx. Surveyor observed LPN I don Personal Protective Equipment (PPE) and enter R20's room. Surveyor did not observe LPN I sanitize hands before entering R20's room. Surveyor observed LPN I grab supplies from R20's drawer and place on bedside table. Surveyor did not observe LPN I sanitize or wipe down bedside table before placing wound dressing supplies on bedside table. LPN I began moving a trash can over to the bedside table. Surveyor observed LPN I begin pulling R20's pants down, pull off the old wound dressing and throw the soiled dressing in the trash can. LPN I removed soiled gloves and sanitized hands. LPN I donned clean gloves and then placed left gloved hand into LPN I's left scrub pocket. LPN I pulled contaminated scissors out of LPN I's pocket. LPN I used contaminated scissors that were located in LPN I's left scrub pocket and cut the calcium alginate for R20's wound. LPN I then took the piece of calcium alginate, which was cut, and packed the contaminated calcium alginate into R20's wound bed on sacrum. LPN I changed gloves and applied the sacral dressing over R20's wound. Surveyor observed LPN I pick up scissors and place back in LPN I's left scrub pocket. LPN I put wound supplies away in drawer, sanitized hands, and walked out of R20's room. On 03/18/25 at 3:47 PM, Surveyor interviewed LPN I and asked LPN I what is LPN I's process when entering an Enhanced Barrier Precaution (EBP) room and prepping wound supplies for R20. LPN I indicated that LPN I would sanitize hands before donning PPE and LPN I usually wipes down the bedside or places a barrier down before placing wound care supplies on table. LPN I indicated to Surveyor that LPN I did not place a barrier or wipe down the bedside table. Surveyor asked LPN I to explain why LPN I pulled a pair of scissors out of LPN I's pocket and used the contaminated scissors to cut R20's calcium alginate that was applied to R20's wound bed. LPN I stated, I thought immediately when I started cutting the calcium alginate. I knew I shouldn't have done that. I am sorry. Surveyor asked LPN I what the normal process for utilizing scissors would be. LPN I indicated that LPN I should have sanitized with an alcohol pad before and after use and to not pull scissors out of LPN I's scrub pocket. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/25 at 2:52 PM, Surveyor interviewed Infection Control Preventionist (ICP) D and asked ICP D what expectation is for prepping for wound care dressing. ICP D indicated that ICP D expects nurses to wipe down surfaces or create a barrier before prepping for supplies. ICP D indicated that all residents with wounds should have designated supplies for their own or that any extra equipment needed is sanitized before and after use for multiple residents. 51095 Example 2 Surveyor requested and received the facility policy titled Hand Hygiene dated 12/2024. The policy in part read: Policy: All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents an visitors. Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated; using proper technique consistent with accepted standards of practice. 2. Hand Hygiene is indicated and will be performed under he conditions listed in, but not limited to, the attached table. ~Before applying and after removing personal protective equipment (PPE), including gloves. On 3/19/25 at 7:32 AM, Surveyor observed Registered Nurse (RN) Q provide wound care to R23. RN Q cleansed wound on R23's coccyx using a 4x4. Surveyor noted RN Q cleaned stool from rectal area. Certifiied Nursing Assistant (CNA) R held skin of R23's buttocks with gloved hands and assisted RN Q with incontinence and wound cares. Immediately after, and without changing gloves, CNA R proceeded to dress R23, put R23's shoes on and used the Hoyer lift to transfer R23 into his wheelchair. CNA R applied pads and leg straps with same gloves she wore for R23's cares. After R23 was up and in his wheelchair, CNA R removed the gloves, and without using any hand hygiene, CNA R put on new gloves and proceeded to R23's bathroom with his toothbrush. On 3/19/25 at 7:55 AM, Surveyor interviewed CNA R who reported she thought she changed gloves after assisting with R23's cares. Surveyor asked CNA R when should hand sanitizer or hand washing be performed. CNA R acknowledged she did not use hand sanitizer or wash her hands after removing her gloves and donning new gloves. CNA R then removed her gloves, used hand sanitizer and put on new gloves. On 3/19/25 at 2:48 PM, Surveyor interviewed ICP/RN D. ICP D acknowledged the expectations of CNAs would be to change gloves after personal cares and wound care and to perform hand hygiene after removing gloves and prior to putting on new gloves to prevent the spread of infectious diseases. 30570 Example 3 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/25 at 6:42 AM, Surveyor observed R61's room door with a posting that read Enhanced Barrier Precautions. Surveyor observed CNA C don gloves and a gown to enter R61's room to prepare R61 for a shower. CNA C explained R61 is on Enhanced Barrier Precautions due to having a feeding tube. CNA C did not perform hand hygiene prior to donning the gown and gloves to care for R61. CNA C rolled R61 side to side in bed to remove bedding from under R61. CNA C expressed the bedding was wet. CNA C bagged the wet linens, removed her gloves and donned gloves to proceed with R1's preparation for his shower. CNA C did not perform hand hygiene when removing her soiled gloves before donning clean gloves. On 3/19/25 at 10:20 AM, Surveyor spoke with CNA C about the observation. CNA C expressed she should have done hand hygiene before donning PPE and with change of gloves. CNA C further expressed it is important to keep everything clean and to prevent cross contamination from dirty to clean. On 3/19/25 at 2:40 PM, Surveyor spoke with Registered Nurse (ICP/RN) D, who is the facility's Infection Control Preventionist, about the observation. ICP/RN D indicated he would expect staff to perform hand hygiene prior to donning PPE and between glove changes to minimize the spread of organisms.