STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525438	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Manor of Lacrosse	2902 East Avenue South LA Crosse, WI 54601

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29360 Based on observation, interview and record review, the facility did not ensure call lights were in reach for 2 of 15 sampled residents (R) (R18 and R2) and 2 of 2 supplemented residents (R9 and R29). R18, R2, and R9 were observed to not have their call lights within reach On 2/26/25, a grievance was filed regarding R29's call light not being within reach. Evidenced by: The facility's call lights - Call System Activation and Response Policy dated 2024, includes, in part, Purpose: The purpose of this procedure is to ensure timely responses to residents' requests and needs. Residents are provided with a means to call for staff assistance through a communication system that directly notifies a staff member or a centralized workstation. Procedure: 1. Each resident is provided with a means to call staff directly for assistance. The call system must be accessible to residents while in bed or other sleeping accommodations withing the resident's room. Example 1 R18 was admitted to the facility on [DATE]. R18's diagnoses include muscle weakness, abnormalities of gait and mobility and pain. R18's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/20/25 indicates R18 has moderate cognitive impairment, needs partial/moderate assistance for sit to stand and partial/moderate assistance for toilet transfer. R18's care plan problem: Resident needs assist with bed mobility, transfers, ambulation and locomotion due to weakness and poor endurance includes, in part, the following approach: Staff to ensure call light is in Resident's reach while in room and encourage to use it to make needs known. Start date: 9/6/24. On 3/3/25 at 9:53 AM, Surveyor observed R18 sitting in his recliner in his room. R18's call light was sitting on the bed. Surveyor asked R18 if he was able to reach the call light. R18 stated he could not reach his call light. R18 stated he needed to have the call light within reach so he could call for assistance. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Example 2 R2 was admitted to the facility on [DATE]. R2's diagnoses include muscle weakness, osteoarthritis, and spinal stenosis. R2's most recent MDS with an ARD of 2/11/25 indicates R2 is cognitively intact and needs supervision with personal hygiene and taking off and putting on footwear. R2's care plan problem: Resident needs assist with dressing, personal hygiene, and bathing due to Left proximal femoral fracture, NWB (non-weight bearing) to LLE (left lower extremity), spinal stenosis, anxiety, osteoarthritis, morbid obesity, HTN (hypertension) and CHF (congestive heart failure). Resident chooses to sleep in recliner. Bed removed from room per resident request includes, in part, the following approach: Staff to ensure call light is in Resident's reach while in room and encourage her to use it to make her needs known. Start date: 10/17/23. On 3/5/25 at 8:34 AM, Surveyor observed R2's call light on the floor next to R2's recliner. R2 stated she needs the call light clipped to her recliner so she can call when she needs assistance. Example 3 R9 was admitted to the facility on [DATE]. R9's diagnoses include diabetes, chronic pain and weakness. R9's most recent MDS with an ARD of 2/20/25 indicates R9 has moderate cognitive impairment, needs partial/moderate assistance with personal hygiene and taking off and putting on footwear. R9's care plan problem: Resident needs assist with dressing, personal hygiene, and bathing due to weakness, sciatica, chronic pain syndrome, depression, ataxic gait and postherpetic nervous system includes, in part, the following approach: Staff to ensure call light is in Resident's reach while in room and encourage her to use it to make her needs known. Start date 3/30/24. On 3/5/25 at 11:07 AM, Surveyor observed R9 sitting in his recliner. R9's call light was on the bedside stand behind R9. On 3/5/25 at 11:09 AM, Surveyor and Licensed Practical Nurse (LPN) L entered R9's room. Surveyor asked LPN L if R9 should have his call light within reach. LPN L stated yes and moved R9's call light, clipping it onto R9's recliner. LPN L stated all resident call lights should be within reach. On 3/5/25 at 8:30 AM, Surveyor interviewed Certified Nursing Assistant (CNA) G. Surveyor asked CNA G when a call light should be accessible to a resident. CNA G stated residents should always have a call light accessible. On 3/5/25 at 8:36 AM. Surveyor interviewed CNA K. Surveyor asked CNA K when a call light should be accessible to a resident. CNA K stated residents should always have a call light accessible. Example 4 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility grievance log includes, in part, Date: 2/26/29, Resident: (R29), Concern: . R29's call light was out of reach one time . It is important to know there are no findings or actions related to this grievance on the grievance log. The facility customer concerns sheet includes, in part, the following: Concern Date: 2/26/25. Concern type: Call light issue. Describe concern: . R29's call light was out of reach one time . Staff person assigned to investigation: DON B (Director of Nursing). Findings: Resident/family not able to give date in which concern occurred. DON B attempted to interview resident on 3/5 at which time the resident had experienced a decline in condition and is not able to be interviewed . Actions: Call light response audits will be completed. Education regarding keeping resident's call light within reach at next nursing meeting scheduled for 3/12. On 3/5/25, Surveyor interviewed DON B. Surveyor asked DON B when a call light should be accessible to a resident. DON B stated residents should always have a call light accessible. Surveyor asked DON B if she had completed any audits or spot checks following R29's grievance that included R29's call light was not in reach. DON B stated no spot checks had been done and no staff had been educated.

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F 0686 Level of Harm - 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** 47657 Based on observation, interview, and record review, the facility did not implement professional standards of practice to ensure that a resident does not develop pressure injuries (PIs), receives necessary treatment and services to promote healing and prevent infection of PIs, or prevent new PIs from developing for 3 of 6 residents (R) reviewed for pressure injuries (R52, R49, R2). R52 was admitted to the facility with a stage II PI and determined to be at high risk for PI. Weekly assessments were not completed consistently, implementing interventions to prevent/improve PIs was not timely, turning and repositioning program was not monitored/reviewed, R52 was not educated on risk vs benefits of repositioning and offloading to prevent/improve PI, and physician was not notified when PI worsened. R52 developed a second stage II PI on 3/4/25. This example is being cited at actual harm. R49 was admitted to the facility with PIs. Weekly assessments were not completed consistently and the intervention of air mattress was added 8 days after admission. Staff did not follow standards of practice for hand hygiene during PI wound care for R2. Findings: According to the National Pressure Injury Advisory Panel (NPIAP) Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline, 2019: Staff should assess and document the physical characteristics of the wound bed and the surrounding skin and soft tissue at least weekly. Weekly wound assessment and documentation should include, in part: Anatomical location, category/stage, size and surface area, tissue type, color, peri wound condition, wound edges, exudate, and odor. NPIAP guidance also recommends repositioning all individuals with or at risk of pressure injuries on an individualized schedule, unless contraindicated. Determine repositioning frequency with consideration to the individual's level of activity and ability to independently reposition. Reposition the individual in such a way that optimal offloading of all bony prominences and maximum redistribution of pressure is achieved. NPIAP guidance also recommends if progress toward healing is not seen within two weeks, the individual, the pressure injury, and the plan of care should be re-evaluated. The facility policy, titled Prevention and Treatment of Skin Breakdown copy right 2018, states: Purpose: Maintaining intact skin is integral to resident health and wellness. Care and serve are delivered to maintain skin integrity and promote skin healing if skin breakdown should occur. Under Section 1 of the policy, states in part .3. Skin integrity is monitored, and abnormal findings are documented, weekly skin audits are performed by a licensed nurse .5. Education is provided to the resident/resident representative as indicated. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Under Section 2 of the policy, states in part: If a resident is admitted with impaired skin integrity or a new PI, the following items are implemented: .5. Evaluate current pressure reduction interventions and revise resident centered care plan, Educate resident/resident representative on skin wound/pressure injury and care plan interventions .10. Weekly the licenses nurse will stage, measure and examine the wound bed and surrounding skin. If wound bed has deteriorated: notify provider 11. Notify the attending provider, resident/resident representative and supervisor if the PI has not shown progress in 2 weeks and/or is deteriorating unexpectedly. Re-evaluate plan as care as appropriate. The facility policy titled Handy Hygiene last revised 09/20/23, states, Purpose: Infection Prevention begins with the basic hand hygiene. By following proper hand hygiene practices, associates will reduce the spread of potentially deadly germs, as well as reduce the risk of healthcare provider colonization caused by germs acquired from the residents. The Hand Hygiene policy section labeled: Times to perform Hand Hygiene are, but not limited to, stated in part, .before and after changing a dressing, upon and after coming in contact with a resident's intact skin, after contact with a resident's body fluids or excretions. Example 1 R52 was admitted to the facility on [DATE] with a diagnosis of streptococcus bacteremia of right lower extremity cellulitis, pressure injury of left buttock and generalized weakness. R52's Minimum Data Set (MDS) assessment, dated 01/08/25, identified R52 scored 15 during a Brief Interview for Mental Status (BIMS), indicating R52 is cognitively intact. R52 requires substantial to maximal assistance for toilet transfer, toilet hygiene, personal hygiene and chair/bed-to-chair transfer. R52 is dependent on staff for sit to stand, and lower body dressing, and identified has a stage II PI and is at risk for PI. On 01/02/25, physician orders of: Bilateral buttocks/inner gluteal crease/L buttock pressure ulcer. Gently clean with warm soapy water. pat dry, apply a thin layer of z-guard as a moisture barrier. may hold in place with viva paper towel three times a day. On 01/02/25, Braden Scale indicated a score of 15 indicating at high risk for pressure ulcers and the facility identified need for interventions of pressure reducing device for chair, turning/repositioning program, pressure ulcer/injury care, and application of ointments/medication other than to feet. On 01/02/25, an admission nurse's notes indicated a stage 2 was identified to left buttock measuring approximately 0.5 cm with a wound bed red, no drainage. Surrounding tissue is excoriated, moist with blanchable erythema. On 01/03/25, an individualized care plan which states in part: I am at risk for alteration of skin status due to impaired mobility, incontinence and generalized weakness. Resident has pressure injury to buttock. Chooses to sleep in recliner, refuses to utilize bed. Resident has history of declining cares despite staff education. The facility entered care plan interventions of: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 01/03/25: turning and positioning program due to decreased mobility with assist of 1. I prefer to be repositioned every 2-3 hours and as needed. 01/27/25: Therapy recommendation: place ROHO cushion where resident is sitting in recliner or wheelchair 01/28/25: followed by wound nurse weekly. 01/28/25: treatment to buttock per MD order. Of note, the facility was unable to provide documentation to support when the ROHO cushion was implemented, or when it was first used in the recliner. On 01/03/25, Wound Rounds Completed: Left buttock: Length: 0.5 cm Width: 0.5 cm. Depth cannot be measured. No exudate. Stage 2. Tissue type: Epithelial tissue. Wound edges/margins: Well, defined wound edges. Skin surrounding wound: Erythema (redness) blanchable. On 01/07/2025, Physical Therapy entered notes stating: R52 was utilizing wheelchair ROHO cushion upside down and therapist placed ROHO in wheelchair the correct side up. On 01/10/25, Wound Rounds competed: Left buttock: Length: 0.4 cm Width: 0.4 cm. Depth cannot be measured. No exudate. Stage 2. Tissue type: Epithelial tissue. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Skin surrounding wound: Pink/normal. Wound healing status: improving. On 01/17/25, Wound Rounds Completed: Left buttock Length: 0.4cm. Width: 0.4cm. Depth cannot be measured. No exudate. Stage 2. Tissue type: Epithelial Tissues. Wound edges/margins: well, defined wound edges. Skin surrounding wound: Pink/normal. Wound healing status: Stable. On 01/23/25, recorded as Late Entry on 01/27/2025, Wound Rounds Completed: Left buttock Length 1.5 cm. Width 0.5 cm. Depth cannot be measured. Exudate: none. Stage 2. Tissues Type: Epithelial Tissue. Wound edges/margins: irregular wound edges. Skin surround wound: pink/normal. Wound healing status: Declining. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 01/23/25, recorded as Late Entry on 01/27/2025, the facility progress notes state in part . Resident does utilize ROHO cushion. Resident observed to only have in wheelchair. Writer educated resident on importance of having ROHO in recliner chair also. Resident was in agreement to try ROHO in recliner. Resident is not always accepting of cares despite staff education and re-approach. Resident does choose to spend majority of time in wheelchair or recliner. Doesn't utilize bed. Of note, the facility was unable to provide supporting documentation of staff educating R52 of importance of accepting cares and repositioning and unable to provide supportive documentation that the physician was updated when PI was noted to be declining, no new interventions were considered, and no change in treatment was initiated. On 02/09/25, Wound Rounds Completed: Left buttock Length 0.6 cm. Width 0.6 cm. Depth cannot be measured. Exudate amount: light. Excaudate color and consistency: Bloody (bright red, thin). Stage 2. Tissue type: Epithelia Tissue. Skin surrounding wound: Pink/normal. Wound healing status: improving. Of note, no weekly wound assessment between 01/23/25 and 02/09/25 On 03/04/25, Wound Rounds Completed: Right Buttock (newly developed PI) Length: 1.0 cm. Width: 1.0 cm. Depth cannot be measured. Exudate amount: light. Exudate color and consistency: Bloody (bright red, thin). Stage 2. Tissue type: Epithelial tissue. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Wound edges/margins: Irregular wound edges. Skin surrounding wound: Pink/normal. Wound healing status: stable. Of note, no weekly wound assessments completed between 02/09/25 and 03/04/25 of left buttock PI, wherein PI worsened and R52 developed a new stage II PI on right buttock. On 03/04/25 at 8:03 AM, Surveyor observed R52 sitting in wheelchair, where R52 remained until 11:45 AM and boarded transportation van for a 45-mile ride to dialysis appointment and not returning until approximately 4:30 P.M. On 03/04/25 at 1:16 PM, Surveyor interviewed Assistant Director of Nursing (ADON) J, who stated becoming aware of a new PI on 02/27/25 during a routine weekly skin assessment completed by nurses. ADON J stated the first wound round assessment was completed today. Of further note, ADON J, who is responsible for weekly wound rounds became aware of the new PI on 02/27/25. No new interventions were put into place upon finding new area, an assessment was not completed until 03/04/15, and the physician was not updated until 03/05/25 during routine rounds. On 03/04/25 at 2:29 PM, Surveyor interviewed Certified Nursing Assistant (CNA) F, who stated R52 has a cushion that is placed on either recliner or wheelchair to sit and stated R52 often refuses on PM shift to get out of recliner and does not use the bed. On 03/04/25 at 2:29 PM, Surveyor interviewed CNA G, who stated R52 doesn't move much on AM shift, but will transfer to wheelchair for meals and then wants to go back into recliner, won't change before going to bed and rarely uses bathroom and is incontinent of urine. On 03/04/25 at 3:18 PM, Surveyor interviewed Regional Nurse H, who stated there was no risk vs benefits document presented to resident regarding offloading. if there would be anything it would be in progress or care plan notes. On 03/04/25 at 3:25 PM, Surveyor reviewed record which shows no documentation noted to support education of risk versus benefits of not repositioning and offloading was provided to R52. On 03/05/25 at 9:39 AM, Surveyor observed Registered Nurse (RN) C conduct wound care on R52. RN C pointed out stage II PI on left buttock and pointed out newly developed stage II PI on right buttock. RN C stated Physician Assistant was made aware of new area today. RN C conducted hand hygiene and placed on gloves, opened clean wound dressing packets and assisted R52 to stand. RN C moved incontinent product that was soiled with urine, away from area and removed old dressing. After cleansing of buttock area, RN C, without removing gloves and/or conducting hand hygiene, placed gloved palm hand on R52's buttocks and placed a clean dressing to PI. On 03/05/25 at 9:50 AM, Surveyor interviewed RN C regarding hand hygiene expectation during wound care. RN C realized RN C had not removed gloves or conducted hand hygiene during wound treatment. RN C stated the expectation would be to remove gloves and conduct hand hygiene after removing old dressings and after assisting with incontinence brief, prior to placing on clean wound treatment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/05/25 at 9:55 AM, Surveyor interviewed Director of Nursing (DON) B regarding no weekly skin assessments completed between 01/27/25-02/09/24; and 02/09/25-03/04/25. DON B confirmed assessments were not completed during these time periods. On 03/05/25 at 10:10 AM, Surveyor interviewed DON B regarding R52's PI on Left buttock that had documentation to support worsening and new pressure injury noted on right buttock was unavoidable. DON B stated was not aware of new area and could not say if implementing the Roho cushion sooner would have made a difference. On 03/05/25 at 11:04 AM, Surveyor interviewed ADON J, asking for information on the start of the Roho cushion. Surveyor was provided an email sent on 01/02/25 (date of R52's admission) from facility staff requesting a Roho cushion. Surveyor was also provided Occupational Therapy (OT) notes dated 01/07/25 which indicates: R52 was utilizing wheelchair ROHO cushion upside down. ADON J was not able to provide documentation to support when ROHO cushion was put into place. On 03/05/25 at 11:10 AM, Surveyor asked ADON J if the worsening of left buttock pressure ulcer and new PI on right buttock were unavoidable. ADON J stated that due to R52's comorbidities, refusals of repositioning and declining to lay in bed does not believe PIs were unavoidable. On 03/05/25 at 12:45 PM, Surveyor interviewed ADON J, who stated the facility does not have any documentation to support repositioning program being completed, risk vs benefit of repositioning education provided to R52, or documentation to support the provider being notified of worsening left buttock PI or development of the new PI on 2/27/25. Example 2 R49 was admitted to facility on 02/12/25, with diagnoses that included pressure ulcer of unspecified site, Stage 2; diabetes, acute kidney failure with a BIMS of 15. R49's admission assessment indicates R49 was admitted with one stage 1 (coccyx) PI and one stage 2 PI (left buttock). On 02/12/25, Braden Scale completed with a score of 15 indicating At Risk with interventions of pressure reducing device for chair and bed, pressure ulcer/injury care, application of nonsurgical dressings, application of ointments/medication other than to feet. On 02/13/25 the facility conducted a weekly wound assessment of PI on left buttock: Length: 1.0 cm. Width: 1.0 cm. Depth: None. Exudate: None. Wound odor: No. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Stage II. Undermining: No. Tissue type: Epithelial Tissue. On 02/26/25, the facility conducted a weekly wound assessment of PI on left buttock: Length 0.2 cm. Width: 0.2 cm. Depth. None. Exudate: None. Wound odor: No. Tissue type: closed/resurfaced. Of note there was no weekly wound assessment completed between 02/13/25 to 02/26/25 for the left buttock. On 02/13/25, Wound Rounds Completed of Stage 2 Coccyx: Length: 0.5 cm. Width: 0.5 cm. Depth: None. Exudate: None. Wound odor: No. Undermining: No. Tissue type: Epithelial Tissue On 02/27/25, weekly wound assessment of Stage 2 PI on coccyx: Length: 0.2cm. Width: 0.2cm. Exudate: None. Wound odor: No. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Tissue Type: Closed/Resurfaced. Wound healing status: Improving. Of note there was no weekly wound assessment completed between 02/13/25 to 02/27/25 for the coccyx PI. On 03/05/25 at 10:16 AM, Surveyor interviewed DON B asking if there is documentation to support consistent weekly wound assessment being conducted of R49's PIs between 02/13/25 and 02/27/25. DON B stated there were no other wound assessments completed. On 03/05/25 at 10:16 AM, Surveyor interviewed DON B regarding expectation of hand hygiene during wound care. DON B stated expectation would be to remove gloves and conduct hand hygiene between going from dirty area to clean area. On 03/05/25 at 11:11 AM, Surveyor interviewed ADON J regarding interventions put into place for pressure injuries. ADON J stated an alternating air mattress was placed on R49's bed. Of note, R49's care plan was not updated until 02/20/25, when facility updated the care plan with a pressure relieving mattress to bed, eight days after R49 was admitted with two PIs. 39713 Example 3 R2's wound orders state, Aquacel AG (antimicrobial primary dressings for use for wounds) to area on buttocks, cover with foam dressing. On 3/04/25 at 2:15 PM, Surveyor observed wound care for R2's PI with RN E completing wound care on R2. RN E entered R2's room, washed hands and applied gloves. RN E cut two strips of Aquacel AG as part of R2's dressing orders. RN E then assisted R2 with standing and pulling down her pants. RN E then removed R2's soiled sacral dressing, placed the two strips of Aquacel AG onto the new sacral dressing and applied to R2's sacrum. RN E then removed her gloves and sanitized her hands, assisted R2 with pulling up her pants and sitting back in her chair. Of note: At no time during the dressing change did RN E remove her gloves or sanitize her hands. On 3/04/25 at 2:20 PM, Surveyor interviewed RN E. Surveyor asked RN E when should you wash your hands during wound care for a PI. RN E stated, before entering the room, after wound care and when leaving the room. Surveyor asked RN E if you should wash hands when going from dirty to clean. RN E stated, Dirty to clean? Surveyor explained dirty to clean and RN stated, Yes. On 3/04/25 at 3:01 PM, Surveyor interviewed DON B. Surveyor asked DON B when hand hygiene should be performed. DON B stated, before entering a room, with glove changes, when going from dirty to clean, and when leaving a room. Surveyor made DON B aware of observation made during wound care for R2's PI.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525438	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Manor of Lacrosse	2902 East Avenue South LA Crosse, WI 54601

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. 46694 Based on observation, interview and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 3 of 5 care observations (R209, R49 and R210). Staff did not perform hand hygiene before putting on gloves when passing medications for R210 and R49. R209's catheter bag was hanging from the garbage can and lying on the floor. Findings: Example 1 Facility policy titled, Hand Hygiene revised date of 9/2023, stated in part: Infection Prevention begins with the basic hand hygiene. By following proper hand hygiene practices, associates will reduce the spread of potentially deadly germs, as well as reduce the risk of healthcare provider colonization caused by germs acquired from the resident .Times to Perform Hand Hygiene are, but not limited to: * Before or after direct resident contact . * Before or after assisting a resident with personal cares . * Upon and after coming in contact with a resident's intact skin, such as when taking vitals or after assisting with lifting . * After removing gloves or aprons . On 03/04/25 at 7:39 AM, Surveyor observed Registered Nurse (RN) C administer medications to R210. R210 received a blood pressure medication that required vital signs to be taken first. Surveyor observed RN C take R210's vital signs and administer medications without performing hand hygiene after RN C took the portable vital sign monitor back to the medication cart and cleaned it with sanitization wipes. RN C did not perform hand hygiene after cleaning the monitor. RN C drew up insulin for R49, took the insulin to R49's room and put on single use gloves for the injection and no hand hygiene was performed. RN C completed administration of insulin, removed the gloves, and performed hand hygiene. Surveyor asked RN C if hand hygiene should have been performed after taking one resident's vital signs and before the administration of another resident's insulin and RN C replied, Yes. On 03/04/25 10:35 AM, Surveyor interviewed Director of Nursing (DON) B and informed DON B of the observation made during the medication administration. Surveyor asked DON B what the expectation is for hand hygiene with glove use. DON B replied the nurse should perform hand hygiene upon entering the room. Surveyor asked DON B what the expectation is with hand hygiene with resident cares such as passing medications. DON B stated hand hygiene is performed between each resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525438	A. Building B. Wing	03/05/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Example 2 Facility policy titled, Prevention of Catheter-Associated Urinary Tract Infections (CAUTI) last reviewed 8/30/2023, stated in part: Purpose: Though prevalence of indwelling urinary catheter use in the long-term care setting is lower than in the acute care setting, catheter-associated UTI (CAUTI) can lead to such complications as cystitis, pyelonephritis, bacteremia, and septic shock. These complications associated with CAUTI can result in a decline in resident function and mobility, acute care hospitalization s, and increased mortality. Prevention is key. On 03/04/25 7:21 AM, Surveyor observed R209's catheter bag hanging from garbage can and resting on the floor. On 03/04/25 7:35 AM, Surveyor pointed out to Certified Nursing Assistant (CNA) D the Foley bag resting on the floor and asked if this was acceptable and CNA D replied, No it is not, I will go fix that right away. On 03/04/25 10:35 AM, Surveyor interviewed DON B about the observation made of the catheter resting on the floor. Surveyor asked DON B what the expectation is for the Foley drainage bag placement. DON B stated the bag should not be on the floor.