| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525543 | A. Building<br>B. Wing | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Marquardt Memorial Manor | 1020 Hill St<br>Watertown, WI 53098 |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44552<br><br>Based on observation, interview, and record review, the facility did not ensure 2 of 3 residents (R3 and R1) reviewed for accidents received adequate supervision and assistance devices to prevent accidents. R3 is being cited at severity level 3 (actual harm).<br><br>R3 experienced a fall with major injury. Surveyor observed fall interventions not in place.<br><br>The facility did not complete a root cause analysis for 12 falls and did not implement appropriate interventions for R1's falls.<br><br>Evidenced by:<br><br>The facility policy, Falls, reviewed 12/5/24, states, in part; .Prevention measures are put in place to reduce the occurrence of falls and risk of injury from falls .c. A licensed nurse will determine the individuals' risk for falls and individualized care needs. If the individual is at risk for falls, then create a falls care plan .b. The care plan will be updated with an identified intervention .<br><br>Example 1:<br><br>R3 was admitted to the facility on [DATE] with diagnoses including stroke, diabetes, anxiety disorder, adult failure to thrive, expressive language disorder, depression, weakness, and muscle weakness.<br><br>R3's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/30/25, indicates R3 has a Brief Interview for Mental Status (BIMS) score of 08 indicating R3 is mildly impaired. R3 has an activated power of attorney.<br><br>(continued on next page) |

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

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

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R3's Care Plan (CP) states, in part; .The resident is moderate risk for falls r/t deconditioning, gait/balance problems, incontinence, seizure disorder, 1/31/25. Risk of falls/falls with injury will be minimized 2/6/25 . Interventions: Anticipate and meet the resident's needs 1/30/25 .Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance 1/30/25 .Bed against wall 2/11/25 .Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs 1/30/25 .ensure that the resident is wearing appropriate footwear- shoes, or non-skid socks when ambulating, transferring or mobilizing in w/c (wheelchair) 1/31/25 . Follow facility fall protocol 1/30/25 .PT/OT evaluate and treat as ordered or PRN 1/30/25 .Side rail on exit side of bed 2/13/25 .The resident needs a safe environment with: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, personal items within reach 1/30/25 .TOILET USE: The resident is totally dependent on 2 staff for toilet use/bedpan/check and change q 2-3 hr (every two to three hours) and prn (as needed) initiated 1/24/25, revision 2/10/25 .TRANSFER: 2A (two assist) with hoyer lift (full body lift) 1/24/25 .<br><br>R3's fall report states, in part; .2/7/25, location: Resident's room. Nursing Description: CNA (Certified Nursing Assistant) was on the resident's L (left) side of bed, rolling resident to the right side of bed (his strong side) to wash him up. CNA reported that he thought the resident was holding on, but then the resident rolled onto the floor on his back. CNA notified the nurse. Description: Resident neuro checks started .New intervention: Staff education provided about checking care plans before taking care of residents to ensure safety. Bed against wall. Side rail on exit side of bed. Resident sent to ED for evaluation for R (right) hip pain, x-ray results show R hip fx. Surgical nailing of R hip done Notes Recommend side railings and using 2 assist with cares.<br><br>(Of note: R3's CP indicates R3 is totally dependent on two (2) staff for toilet use/bedpan/check and change q 2-3 hr and prn initiated 1/24/25, revision 2/10/25 .TRANSFER: 2A with hoyer lift (full body lift) 1/24/25 .)<br><br>Nursing Progress Note, states, in part; .2/7/25 .At this time resident c/o pain to CNA, to which they came to nurses station to report his is 10/10. Was reported to writer that res had a fall around 2000-ish (~8:00PM). Entered res room and told res that the sheet is going to be rolled off to exam bilateral legs. Bilateral (legs) are stiff like sticks, res has pain to Rt (right) hip rated 10/10 but can't bend legs d/t stroke with no deformity rotation or shortening noticed. Just had pain At this time PM nurse explained about res fall and now Rt hip pain, to which APNP (Advanced Practice Nurse Practitioner) ordered to send res to be seeing [sic] in ER .<br><br>R3's CNA Kardex states, in part; .Bed Mobility .Bed against wall .Toileting .TOILET USE the resident is totally dependent on 2 staff for toilet use/bedpan/check and change q 2-3 hr and prn .<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 4/10/25 at 2:30 PM, CNA C (Certified Nursing Assistant) indicated he was the CNA that was in R3's bedroom at the time of R3's fall on 2/7/25. CNA C indicated he was assisting R3 in cleaning up, rolled R3 towards the window (left side of resident) while standing behind resident on right side. CNA C indicated prior to fall CNA C was repositioning resident with 1 staff and that CNAC had done this many times. CNA C indicated R3 rolled on the floor and that CNA C immediately called for the nurse. CNA C indicated R3 was pretty new to the facility during this time and that this was his only fall. CNA C indicated CNA C did receive education after the incident. CNA C indicated the education was about the fall, what not to do in the future, following care plans, and new interventions for R3. CNA C indicated new interventions in place are 2 staff at all times and side rail on side of bed for resident to utilize when rolling. CNA C and Surveyor walked into R3's bedroom. R3's bedroom door had been closed. Surveyor observed R3's call light on the ground and R3's bed positioned in the middle of bedroom. CNA C indicated R3 was unable to call for anyone because call light was on ground. Surveyor asked CNA C if call light should be within reach. CNA C indicated it should be near resident.<br><br>(Of note: R3's bed was not against the wall and the call light was not within reach per R3's care plan.)<br><br>On 4/10/25 at 4:49 PM, Director of Nursing B (DON) indicated CNA C's education was regarding following and checking care plans prior to assisting residents. DON B indicated the education was also regarding the concern that CNA C rolled R3 away from CNA C. DON B indicated she could provide education documentation. Surveyor reviewed CNA's education. DON B provided documentation of education that was provided to all staff that work with R3 and documentation from All Staff meeting in February as well.<br><br>(Of note: Surveyor observed R3's care plan not being followed on 4/10/25)<br><br>On 4/10/25 at 6:20 PM, Director of Nursing B (DON) indicated she would expect that fall interventions to be followed and in place. DON B indicated she would expect call lights to be within resident reach. DON B indicated R3's bed had been moved right after the fall. DON B indicated R3's bed is no longer against the wall. (Of note: R3's bed against the wall remains on R3's care plan and CNA Kardex.)<br><br>The facility failed to ensure residents assistance devices are in place to prevent accidents.<br><br>49436<br><br>Example 2:<br><br>R1 admitted to the facility on [DATE] with diagnoses including lymphocytic leukemia (a type of blood cancer), dementia, and right hip fracture.<br><br>R1's 12/7/24 Brief Interview for Mental Status (BIMS) had a score of 8, indicating R1's cognition is moderately impaired.<br><br>R1's comprehensive care plan includes the following:<br><br>Focus: R1 has an ADL self-care performance deficit (initiated on 12/3/24 and revised on 3/11/25).<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interventions: Bed mobility: 1 assist (initiated on 12/3/24 and revised on 2/18/25). Toilet use: 1 assist, urinal within reach (initiated on 12/3/24 and revised on 2/18/25). Transfer: pivot transfer with assist of 1, front wheeled walker and gait belt (initiated on 12/3/24 and revised on 2/12/25). Wheelchair for distance (initiated on 12/3/24).<br><br>Focus: R1 has impaired cognitive function related to Dementia (initiated 1/4/25).<br><br>Interventions: Anticipate and meet needs (initiated on 1/4/25).<br><br>Focus: R1 uses psychotropic medications related to Dementia with behaviors (initiated 12/31/24 and revised on 3/11/25).<br><br>Interventions: Monitor/document/report PRN (As Needed) and adverse reactions of psychotropic medications: unsteady gait, shuffling gait, and frequent falls (initiated on 12/31/24).<br><br>Focus: R1 is at risk for falls related to need for assist with mobility, balance concerns, impulsivity, and poor safety awareness (initiated on 12/3/24 and revised on 3/11/25).<br><br>Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance (initiated on 12/3/24 and revised on 3/10/25).<br><br>Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility (initiated on 12/3/24).<br><br>Ensure that the resident is wearing appropriate footwear when ambulating, transferring or mobilizing in wheelchair (initiated on 12/3/24).<br><br>Follow facility fall protocol (initiated on 12/3/24).<br><br>PT/OT (Physical Therapy/Occupational Therapy) evaluate and treat as ordered and PRN (As Needed) (initiated on 12/3/24).<br><br>The resident needs a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; personal items within reach (initiated on 12/3/24).<br><br>NOC (night) shift to offer toileting 4:00 AM - 6:00 AM as well as NOC rounds (initiated on 1/12/25 and revised on 2/17/25).<br><br>Offer toileting upon rising, before/after meals, at HS (Hours of Sleep/bedtime), and PRN (initiated 1/14/25).<br><br>Visual cues placed in resident's room to remind resident to call for assistance (initiated on 1/19/25).<br><br>Don't leave resident unattended while awake in room, bathroom (use privacy curtain), church, activities, nurses station, and/or dining room (initiated 1/23/25).<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Encourage resident to be in room only during sleeping hours (initiated on 2/17/25).<br><br>HS (Hours of Sleep/bedtime) Seroquel (antipsychotic medication) increased (initiated on 2/21/25).<br><br>Ensure resident is wearing grippy socks while in bed (initiated 2/26/25).<br><br>Resident's room moved closer to nurse's station (initiated on 2/28/25).<br><br>Incident 1<br><br>R1's incident report dated 12/11/24 includes the following:<br><br>Unwitnessed fall on 12/11/24 at 7:10 AM. Location: Resident's room. Nursing Description: Staff found resident on floor in room. Resident Description: Resident combative and unable to answer. Description of Action Taken: Nurse tried to assess both hips, appeared all was wnl (Within Normal Limits). Sent out to the ER (emergency room ). New Intervention: offer and encourage toileting every 2 hours and as needed. Notes: Resident was alert but yelling, and swinging at staff. Yelled yes to paibn [sic]. Other: He is Easy stand (Mechanical lift used to aid in transferring residents). He was in bed transferred self. [NAME] is across room, and call light is on bed. He usually yells if don't answer is [sic] light when he is using it Staff normally anticipate his needs ahead time.<br><br>R1's 12/11/24 after visit summary from the Emergency Department states, in part: He (R1) has had x-rays done and we are seeing an acute mildly displaced subtrochanteric periprosthetic fracture of the proximal left femur .nonsurgical. He will be sent back to the nursing facility with outpatient clinic follow up with orthopedics.<br><br>On 4/10/25 at 5:00 PM, Surveyor interviewed DON B (Director of Nursing) regarding R1's fall (incident 1). DON B indicated a root cause analysis is performed using a QA (Quality Assurance) form. DON B indicated a root cause is only done when there is an injury. Surveyor asked about the root cause for R1's fall on 12/11/24 that resulted in a left femur fracture. DON B indicated there was not one. Surveyor asked DON B what the facility's process for toileting residents with dementia. DON B indicated the standard of practice is to offer toileting every 2 hours and as needed. Surveyor asked DON B if she would consider the intervention offer and encourage toileting every 2 hours and as needed an appropriate intervention for a fall since that is the standard and was already being done for R1. DON B indicated it was not an appropriate intervention.<br><br>Of note, there was no intervention placed on the care plan following this fall.<br><br>Incident 2<br><br>R1's incident report dated 1/8/25 includes the following:<br><br>Unwitnessed fall on 1/8/25 at 5:30 AM. Nursing Description: Resident found in room lying supine (lying face upward) on the floor. Legs pointed toward the toilet, torso in front of the door. New intervention: Offer toileting with every NOC (night) round while awake. Education: Recommended resident use call light to ask for help with transfers rather than do them unassisted.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 4/10/24 at 5:00 PM, Surveyor interviewed DON B regarding R1's fall. DON B indicated a root cause analysis was not completed. DON B indicated that offering toileting on night rounds is a standard of practice and not a new intervention. DON B indicated this is not an appropriate intervention.<br><br>Incident 3<br><br>R1's incident report dated 1/12/25 includes the following:<br><br>Unwitnessed fall on 1/12/25 at 8:30 AM. Nursing Description: Res (R1) calling out. Observed res (R1) sitting on buttocks outside bathroom door. No shoes. Had brief and t-shirt on. Res attempting to self-transfer to toilet. No injury noted. Resident Description: Resident was requesting to use toilet. Description of Action Take: 2 assist with hoyer off floor. CNA (Certified Nursing Assistant) toileted and put him in his recliner. Neuro checks started. NOC shift to offer toileting 4:00 AM - 6:00 AM.<br><br>On 4/10/25 at 5:00 PM, Surveyor interviewed DON B regarding night shift rounds. DON B indicated staff offer toileting on rounds as a standard of practice. DON B indicated offering toileting between 4:00 AM and 6:00 AM would not be a new intervention as staff should have been doing this as a standard of practice already.<br><br>Incident 4<br><br>R1's incident report dated 1/14/25 includes the following:<br><br>Unwitnessed fall on 1/14/25 at 6:25 AM. Nursing Description: Resident found on floor at 6:25 AM. Resident was incontinent of urine. No injury observed. VSS (Vital signs stable). Neurological checks initiated. Resident Description: Resident is unaware of what happened. Description of Action Taken: Resident transferred into wheelchair. New intervention: Offer toileting upon rising, before/after meals, at HS (hours of sleep), and PRN (As needed).<br><br>On 4/10/25 at 5:00 PM, Surveyor interviewed DON B. DON B indicated offering toileting upon rising, before/after meals, at HS, and PRN is standard of practice and staff should have already been doing this. DON B indicated this would not be considered a new intervention for R1.<br><br>Incident 5<br><br>R1's incident report dated 1/23/25 includes the following:<br><br>Unwitnessed fall on 1/23/25 at 1:45 AM. Nursing Description: Resident found in his room lying on the floor in the supine position near his BR (Bathroom). Description of Action Taken: Encouraged resident to use his call light to ask for assistance when needing to use the BR. New intervention: Don't leave resident unattended while awake in room, bathroom (use privacy curtain), church, activities, nurses station, and/or dining room.<br><br>Incident 6<br><br>R1's incident report dated 2/16/25 includes the following:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Unwitnessed fall on 2/16/25 at 3:00 PM. Nursing Description: Resident found laying on his back in the middle of room. Active rom (Range of Motion) and able to move all extremities. No injuries noted. New intervention: Resident assisted into w/c (wheelchair) with 2 assist and gait belt transferred with some shakiness. Encourage resident to be in room only during sleeping hours.<br><br>Of note, the previous intervention added on 1/23/25 states Don't leave resident unattended while awake in room, bathroom (use privacy curtain), church, activities, nurses station, and/or dining room.<br><br>Incident 7<br><br>R1's incident report dated 2/20/25 includes the following:<br><br>Unwitnessed fall on 2/20/25 at 4:30 AM. Nursing Description: Found lying on LT (left) side on floor at FOB (Foot of Bed). Description of Action Taken: Assisted back to bed. Reminded resident to use call light for assistance. New intervention: HS (Hours of sleep) Seroquel (antipsychotic medication) increased. Fall mat on exit side of bed.<br><br>Of note, the intervention fall mat on exit side of bed was not added to the care plan.<br><br>Incident 8<br><br>R1's incident report dated 2/25/25 includes the following:<br><br>Unwitnessed fall on 2/25/25 at 12:00 AM. Nursing Description: CNAs came to nurses station 1 to inform the nurses about a fall. Observed resident whit [sic] his knees to chest, and then resident put himself laid [sic] on the ground on his back. Observed w/c between the foot of the bed, and walker was between TV, that is on dresser and the closet. He was barefooted. Called light within reach clipped to her [sic] bedsheet but not on. Res then does not follow directions. Res was yelling I have to pee I need the bucket. New intervention: Ensure grippy socks are on while resident is in bed.<br><br>Incident 9<br><br>R1's incident report dated 2/27/25 includes the following:<br><br>Witnessed fall on 2/27/25 at 3:50 PM. Location: Lounge. Nursing Description: Res was put in recliner as res appeared tired/restless. He appeared relaxed in the beginning but shortly after being put in the recliner, he moved himself towards the foot of the recliner and rolled onto the floor. Res noted to be lying on his back on the floor. New intervention: Room was moved closer to nurses station.<br><br>Of note, this fall occurred in the lounge while being supervised. R1 was not in his room at the time of the fall.<br><br>Incident 10<br><br>R1's incident report dated 3/4/25 includes the following:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50285<br><br>Based on observations, interviews, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for 1 of 1 resident (R4) reviewed for transmission-based precautions.<br><br>R4 had a sign posted on his door that he was under isolation for droplet precautions; however, a staff member entered R4's room without following the droplet precaution protocol, wearing the appropriate PPE (Personal Protective Equipment) or performing hand hygiene per standards of practice.<br><br>This is evidenced by:<br><br>Facility policy, titled Infection Prevention and Control Program dated 6/14/17, with last review date of 5/8/25, states, in part: Policy: To prevent the development and transmission of disease and infection, the organization will follow the Infection Prevention and Control Program procedures below. Procedure: 1. Prevention and Surveillance. The facility will: . ii. Prevent and control outbreaks and cross-contamination using transmission-based precautions in addition to standard precautions; . v. Utilize hand hygiene practices consistent with accepted standards of practice; to reduce the spread of infections and prevent cross-contamination; . 2. Identification: i. Standard and transmission-based precautions are to be followed to prevent the spread of infections, use the Center for Disease Control Guideline (CDC) for Isolation Precautions to determine precautions . 5. Controlling Infections and Communicable Diseases: . ii. Signage will be posted per current CDC recommendations. 6. Education: i. All staff will receive mandatory education/training about Infection Control upon hire, and annually .<br><br>R4 was admitted to the facility on [DATE].<br><br>R4's Nursing Progress Notes include the following:<br><br>On 5/11/25 at 8:59 PM, Res (resident) has a non-productive cough and nasal congestion. Lungs clear to auscultation. See VS (vital signs) section also.<br><br>On 5/13/25 at 12:26 AM, Wheezing noted. Fluids encouraged.<br><br>On 5/13/25 at 8:50 AM, On NOC (overnight) shift he had a 100.5 temp but was given ice and Tylenol. Currently has a temp of 98.4 and is 92% on 4L (liters of oxygen). Swabbed for influenza. Pending results. Notified POA (Power of Attorney).<br><br>On 5/13/25 at 4:06 PM, Has occasional cough noted. Fluids encouraged.<br><br>On 5/14/25 at 2:28 AM, Resident sleeping well with O2 (oxygen) and HOB (head of bed) elevated CXR (chest x-ray) results sent ., orders received. See also VS section.<br><br>On 5/14/25 at 6:47 AM, Influenza swab taken to lab.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525543 | A. Building<br>B. Wing | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marquardt Memorial Manor | 1020 Hill St<br>Watertown, WI 53098 |

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

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/14/25, an order was received for R4 for Levofloxacin Oral Tablet 750 mg (milligram). Give 1 tablet my mouth in the morning for pneumonia. Start Levofloxacin 750 mg daily po (by mouth) for 5 days.<br><br>On 5/15/25 at 8:21 PM, Auscultated diminished lung sounds throughout . 3L per nasal canula. Scheduled Duo neb given x1 this shift. Continues on antibiotic for pleural effusion (a collection of fluid around the lungs); no side effects noted.<br><br>On 5/20/25 at 11:48 AM, Surveyor observed that R4 had a Droplet Precaution sign on his door that indicated everyone must hand hygiene when entering and leaving the room and wear a mask when entering the room. Surveyor observed CNA D (Certified Nursing Assistant) enter R4's without wearing a mask or performing hand hygiene.<br><br>On 5/20/25 at 11:55 AM, Surveyor observed CNA D enter R4's room and deliver his lunch tray without wearing a mask or performing hand hygiene.<br><br>On 5/20/25 at 12:33 PM, Surveyor interviewed LPN F (Licensed Practical Nurse) what staff should be doing if a resident is on droplet precautions. LPN F stated that staff should be wearing a mask when they go in and using hand sanitizer when they go in and out.<br><br>On 5/20/25 at 12:38 PM, Surveyor interviewed LPN G and asked her what staff should be doing if a resident is on droplet precautions. LPN G stated that staff should be wearing a mask and gloves and hand hygiene when they go in and out. Surveyor asked LPN G if staff should be doing this every time they enter and exit a room that is under isolation. LPN G stated yes, every time.<br><br>On 5/20/25 at 12:41 PM, Surveyor interviewed CNA D and asked him what staff should be doing if a resident on droplet precautions. CNA D stated masking and wearing goggles. Surveyor asked CNA D if these precautions should be in place every time when entering a room that is under isolation. CNA D stated that the precautions only needed to be implemented when doing cares with a resident.<br><br>On 5/20/25 at 12:43 PM, Surveyor interviewed CNA H and asked her what staff should be doing if a resident is on droplet precautions. CNA H stated that they need to wear gown, mask and gloves every time when going in the room.<br><br>On 5/20/25 at 12:47 PM, Surveyor interviewed MT I (Med Tech) and asked her what staff should be doing if a resident is on droplet precautions. MT I stated that they should use PPE such as gown, gloves and mask every time when going in the room.<br><br>On 5/20/25 at 2:40 PM, Surveyor interviewed DON B (Director of Nursing) and asked her what her expectation was for staff when entering the room of a resident on droplet precautions. DON B stated that it was her expectation that staff mask every time they enter the room and gloves if they are providing cares to the resident.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/20/25 at 3:25 PM, Surveyor interviewed NHA A (Nursing Home Administrator) and asked her if she expected staff to follow the droplet precaution policy, including performing hand hygiene when entering and exiting the room, and wearing a mask every time when entering the room. NHA A stated that today at lunch time there were extra staff helping hand out lunch trays, so it was possible one of the managers entered a precaution room without following the droplet precaution guidelines. NHA A indicated that R4 was supposed to have been taken off precautions on 5/18/25. Surveyor asked if all staff, including managers, would see a Droplet Precaution sign on a resident's door should they follow the Infection Control policy? NHA A stated that it is difficult with all these different precautions and the signs can be sign numbing for staff. |