STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525609	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Marys Home for the Aged	1635 S 21st Street Manitowoc, WI 54220

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident representative interview and record review, the facility did not ensure a new diagnosis of schizophrenia met clinical criteria for 1 resident (R) (R1) of 1 sampled resident.R1 was admitted to the facility on [DATE]. On 6/6/25, R1 received a new diagnosis of schizophrenia. The facility did not have evidence that R1's diagnosis met the diagnostic criteria in The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Findings includeAccording to The American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (a resource used by mental health professionals to diagnose mental disorders), to meet the criteria for a diagnosis of schizophrenia, the patient must have experienced two (or more) of the following, each present for a significant portion of time during a 1 month period (or less if successfully treated). At least one of these must be delusions, hallucinations, or disorganized speech: delusions; hallucinations; disorganized speech (e.g., frequent derailment or incoherence); grossly disorganized or catatonic behavior; negative symptoms (i.e., diminished emotional expression or avolition) .Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet the above criteria (i.e., active phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested only by negative symptoms or by two or more symptoms listed above present in an attenuated form For a significant portion of time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or selfcare is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is a failure to achieve expected level of interpersonal, academic, or occupational functioning) .Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition .If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).On 12/1/25, Surveyor reviewed R1's medical record. R1 had diagnoses including dementia, generalized anxiety disorder, major depressive disorder, and insomnia due to other mental disorder. On 6/6/25, a diagnosis of schizophrenia was added to R1's diagnoses list. R1's Minimum Data Set (MDS) assessment, dated 9/4/25, had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R1 had severe cognitive impairment. R1 had a court-ordered Guardian for decision making.A care plan, dated 6/20/25, indicated R1 required antidepressant medication due to depression, had occasional issues with mood and behavior due to dementia, anxiety, and restlessness, and required the use of psychotropic medication due to a diagnosis of schizophrenia. R1's physician orders included the following:~ Trazadone 50 milligrams (mg) for anxiety/insomnia~ Abilify 2 mg for depression~ Sertraline 50 mg for generalized anxiety disorder~ Donepezil HCL 10 mg for dementiaDespite the indication in R1's care plan, Surveyor noted R1 did not have any medication orders for a diagnosis of schizophrenia.Psychiatric provider notes (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during R1's stay at the facility included diagnoses of generalized anxiety disorder, major depressive disorder, and insomnia due to other mental disorder. The notes did not include a diagnosis of schizophrenia or indicate R1 had delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, or diminished emotional expressions that were continuous signs of the disturbance for at least 6 months. All psychotropic medications were prescribed and monitored by R1's psychiatric provider.On 12/2/25, Surveyor reviewed R1's behavioral charting from 12/1/24 through 12/2/25. Surveyor noted no documentation of behaviors to support a diagnosis of schizophrenia.On 12/2/25 at 9:32 AM, Surveyor interviewed Director of Nursing (DON)-B who indicated the facility's MDS nurse who worked remotely found the schizophrenia diagnosis in documentation for R1. The diagnosis was then added to R1's MDS assessment and a new Preadmission Screening and Resident Review (PASSR) was completed. DON-B indicated DON-B would provide the medical documentation regarding the schizophrenia diagnosis.On 12/2/25 at 1:35 PM, Surveyor interviewed DON-B who contacted the MDS nurse for the documentation that prompted the MDS nurse to update R1's MDS assessment on 6/6/25 with a diagnosis of schizophrenia. On 12/3/25 at 11:09 AM, DON-B provided Surveyor with a physician note with a schizophrenia diagnosis. The Skilled Nursing Home Physician Visit note, dated 6/6/25, was signed by a primary care physician (PCP). DON-B was not aware of the PCP and thought the visit occurred in a physician's office. The note indicated the visit was conducted at the facility and was a required skilled nursing facility visit for Medicare compliance. DON-B indicated DON-B would provide additional information prior to the 6/6/25 visit that supported the diagnosis of schizophrenia.On 12/3/25 at 11:15 AM, DON-B approached Surveyor and stated DON-B spoke with R1's Guardian ((GD)-F) who indicated R1 had a history of mental illness and an inpatient mental health stay years ago. DON-B indicated DON-B would check the facility's health care system for more information prior to R1's admission. On 12/3/25 at 12:12 PM, Surveyor interviewed GD-F who indicated R1 never had a diagnosis of schizophrenia. GD-F was not aware that a schizophrenia diagnosis was added to R1's diagnoses list. GD-F confirmed R1 had an inpatient mental health stay in 2018 that included paranoia which was attributed to multiple medication changes. GD-F indicated the only other diagnosis that was proposed was bipolar disorder which was never diagnosed. GD-F verified R1 was followed by psychiatry for several years. GD-F indicated R1 had had no ill effects on R1's mental health since the 2018 inpatient stay when R1 was detoxed off all medications and then restarted on medications that are still prescribed. GD-F indicated the medications have successfully managed R1's mental health and R1 has been happy and doing well at the facility. GD-F expressed concern about the physician note that mentioned a schizophrenia diagnosis and indicated R1's psychiatric provider handles all mental health treatment for R1. GD-F was concerned that a new diagnosis was given without GD-F's knowledge or consultation. GD-F did not want medication changes for R1 based on the diagnosis. On 12/3/25, DON-B provided Surveyor with documentation from R1's psychiatric provider for 9/21/21 through R1's admission to the facility. The documentation included diagnoses of generalized anxiety disorder, major depressive disorder, and insomnia due to other mental disorder. DON-B was not aware of any supporting documentation for the schizophrenia diagnosis.

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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** Based on observation, staff interview, and record review, the facility did not ensure the resident environment remained as free of accident hazards as possible for 2 residents (R) (R23 and R12) of 3 sampled residents.R23 had a history of falls. R23's care plan contained an intervention for a call light within reach with prompt response to requests. During multiple observations, R23 did not have a call light within reach.R12 had a history of falls. R12's care plan contained an intervention to have a walker in front of R12 when in bed and in R12's recliner. During multiple observations, R12 did not have a walker in front of R12 when in bed or the recliner.Findings include: The facility's Fall Prevention Program policy, revised 1/8/19, indicates: .1. Ensure the environment is free from accident hazards over which we have control and that we provide supervision and assistive devices to each resident to prevent avoidable accidents in accordance with state and federal regulations. 1. On 12/1/25, Surveyor reviewed R23's medical record. R23 had diagnoses including dementia, muscle weakness, abnormalities of gait and mobility, age-related physical debility, history of falling, difficulty in walking, and cognitive communication deficit. R23's Minimum Data Set (MDS) assessment, dated 11/13/25, had a Brief Interview for Mental Status (BIMS) score of 0 out of 15 which indicated R23 had severe cognitive impairment. R23 had an activated decision maker for healthcare decisions. A care plan, dated 11/30/25, indicated R23 had falls related to anxiety and dementia and needed extensive assistance of one staff and a Medstand for transfers. The care plan contained the following interventions: white socks during weekdays (otherwise attempts to self-transfer to change), assist of one for all activities of daily living (ADLs), call light within reach with prompt response to all requests (dated 3/1/24) and 30-minute safety checks (dated 11/30/25). R23's medical record indicated R23 fell on 1/15/25, 7/13/25, and 11/20/25. A fall investigation, dated 1/15/25, indicated R23 did not have access to the call light, reached to pick up a blanket, fell face forward out of the wheelchair, and obtained a bruise and abrasion on the forehead. On 12/1/25 at 8:08 AM, Surveyor observed R23 in a recliner without a call light within reach. Surveyor observed an easy button call light on the nightstand in front of R23's bed which was not within reach. A call light attached to the wall was tucked behind the bed and not within reach. On 12/1/25 at 1:35 PM, Surveyor observed R23 asleep in a recliner without a call light within reach. Surveyor observed an easy button call light on the nightstand in front of R23's bed which was not within reach. A call light attached to the wall was tucked behind the bed and not within reach. On 12/2/25 at 7:43 AM, Surveyor observed R23 in the middle of R23's room in a wheelchair without a call light within reach. Surveyor observed an easy button call light on the nightstand in front of R23's bed which was not within reach. A call light attached to the wall was tucked behind the bed and not within reach. On 12/2/25 at 11:07 AM, Surveyor observed R23 in a recliner without a call light within reach. Surveyor observed an easy button call light on the nightstand in front of R23's bed which was not (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	within reach. A call light attached to the wall was tucked behind the bed and not within reach. Surveyor interviewed Certified Nursing Assistant (CNA)-D who transferred R23 into the recliner. CNA-D indicated CNA-D forgot to give R23 the call light and confirmed R23 did not have access to a call light. On 12/3/25 at 9:25 AM and 10:02 AM, Surveyor observed R23 in a recliner without a call light within reach. Surveyor observed an easy button call light hooked to R23's bed and a push button call light behind the bed. On 12/3/25 at 1:07 PM, Surveyor interviewed Director of Nursing (DON)-B who confirmed staff are trained on the facility's policy that indicates all residents should have access to a call light. DON-B indicated staff should ensure residents are provided with a call light in order to receive prompt assistance. 2. From 12/1/25 to 12/3/25, Surveyor reviewed R12's medical record. R12 was admitted to the facility on [DATE] and had a diagnosis of hemiplegia. A care plan, with an initiation date of 5/3/23, indicated R12 had falls related to cognitive decline and lack of safety awareness and required moderate assistance with ambulation. The care plan contained an intervention, dated 1/28/24, for a walker within reach at all times - at the bedside or in front of the recliner when sitting. R12's CNA care plan (an abbreviated care plan used by nursing staff) indicated the walker should be at the bedside when R12 is in bed and in front of the recliner when R12 is sitting in the room. On 12/1/25 at 9:54 AM and 12/2/25 at 10:01 AM, Surveyor observed R12 in bed with the bed in the lowest position. R12's walker was not in front of the bed. Surveyor noted the walker was on the opposite side of the room. On 12/2/25 at 1:43 PM, Surveyor observed R12 in a recliner. R12's walker was not in front of R12. Surveyor interviewed CNA-D who indicated CNA-D did not work on R12's unit often and the CNA who was working was new. When Surveyor indicated R12's care plan (posted in the room) indicated R12 should have a walker in front of the bed and/or recliner, CNA-D put the walker in front of R12. CNA-D indicated care plans should be followed. On 12/2/25 at 3:13 PM, Surveyor interviewed DON-B who confirmed care plans should be followed and R12 should have a walker next to R12 when in bed and the recliner.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and record review, the facility did not provide necessary respiratory care and services for 2 residents (R) (R1 and R5) of 2 sampled residents.R1 had diagnoses of obstructive sleep apnea (OSA) and chronic obstructive pulmonary disease (COPD). R1 had an order for a bilevel positive airway pressure (BiPAP) machine with oxygen provided by a concentrator and connected to the machine via tubing. Staff did not clean R1's BiPAP machine per manufacturer's instructions. In addition, two open one-gallon jugs of distilled water for use with R1's BiPAP machine were expired. R5 had a diagnosis of OSA and an order for a continuous positive airway pressure (CPAP) machine. Staff did not clean R5's CPAP machine per manufacturer's instructions.Findings include:The facility's Using a CPAP machine policy, dated [DATE], indicates: CPAP is used to treat patients with obstructive sleep apnea or to help decrease a patient's work of breathing while increasing oxygen saturation in the blood. Equipment: nasal mask or full face mask; soft cap; whisper swivel, tubing; CPAP (BiPAP if applicable) in-line pressure adapters (if supplemental oxygen is prescribed); .Since there are various models of CPAP units, it is not practical to include every manual within this policy and procedure. A copy of the manual should accompany the specific unit being used for a resident. If the manual is not present, call (the respiratory care provider) and an additional one will be provided to you .Precautions: Wash soft cap or headgear in mild soap, rinse and lay flat, or hang to dry as needed .The [NAME] Dream Station manufacturer's manual indicates: .Cleaning the Tubing .Hand wash the tubing and the mask and adaptor (if included) before first use and daily. For daily cleaning, disconnect the tubing from the device and the mask, and, if included, disconnect the mask adaptor from the tubing. For the flexible tubing, gently wash the tubing and mask and adaptor in a solution of warm water and liquid dish soap. Rinse thoroughly. Air dry. Inspect the tubing and mask adaptor for damage or wear. Discard and replace if necessary .Using expired distilled water in a [NAME] CPAP machine is not recommended due to the potential risks associated with using contaminated water. The water may contain bacteria or other contaminants that could be harmful if inhaled. It is crucial to use fresh, filtered water to ensure safe and effective treatment. If you have an expired distilled water bottle, it is best to discard it and replace it with fresh distilled water to maintain the health and functionality of your CPAP machine.The Air Fit ResMed Mask user guide indicates: Cleaning Your Mask: Mask and headgear should only be handwashed by gently rubbing in warm (approximately 86 Fahrenheit (F)/30 Celsius (C)) water using mild soap. All components should be rinsed well with drinking quality water and allowed to air dry out of direct sunlight .Daily/After Each Use: Disassemble the mask components according to the disassembly instructions. Handwash the separated mask components (excluding headgear and soft sleeves). To optimize the mask seal, facial oils should be removed from the cushion after use. Use a soft bristle brush to clean the vent. Inspect each component and, if required, repeat washing until visually clean. Rinse all components well with drinking quality water and allow to air dry out of direct sunlight. When all components are dry, reassemble according to the reassembly instructions. Disposable filter to be replaced monthly.Harvard Health Publishing of Harvard Medical school, dated [DATE], indicates:.A CPAP machine is one of the best treatments for people with obstructive sleep apnea, a condition that causes you to stop breathing periodically during sleep. The pauses in sleep occur when muscles in the throat relax so much that they block the airway. CPAP keeps your airway open. The CPAP system consists of a small bedside pump that pushes a forceful stream of air through a tube and into a mask you wear while you sleep. Bacteria and mold can accumulate in different parts of the device .The mask sits on the face, in contact with organisms on the skin. Over time, bacteria and oils on a dirty mask may give you a rash or infection on the skin .Given that the mask, tubing, and other components are breathed into and deliver air throughout the night, their cleanliness can be a serious health concern. Daily cleaning removes dangerous microbes, mold, dust, and debris .CPAP machines are (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	humid and often warm, making them the perfect home for mold, bacteria, viruses, and other harmful microbes. Cleaning your CPAP components regularly washes these microbes away and prevents them from reaching dangerous levels, but neglecting your CPAP machine's hygiene can lead to both acute and chronic respiratory conditions.1.On [DATE], Surveyor reviewed R1's medical record. R1 had diagnoses including dementia, acute and chronic respiratory failure, COPD, hypertensive heart and chronic kidney disease with diabetes type 2, chronic kidney disease stage 3, and pneumonia (on [DATE]) treated with antibiotics until [DATE]. R1's Minimum Data Set (MDS) assessment, dated [DATE], had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 which indicated R1 had severe cognitive impairment. R1 had a court-ordered Guardian for decision making. On [DATE] at 10:15 AM, Surveyor interviewed R1 and observed a BiPAP machine with supplemental oxygen attached in the room. R1 was using supplemental oxygen from an oxygen concentrator. Surveyor noted R1's BiPAP mask appeared dirty/greasy and contained white matter around the inside and outside. R1 was not sure who cleaned the BiPAP machine and supplies. Surveyor also observed two open and partially used one gallon jugs of distilled water next to the nightstand. One jug contained a use-by date of [DATE] and the other jug contained a use-by date of [DATE]. On [DATE] at 1:45 PM, Surveyor noted R1's BiPAP mask appeared dirty/greasy and contained white matter around the inside and outside similar to Surveyor's earlier observation. On [DATE] at 12:57 PM, Surveyor noted R1's BiPAP mask appeared dirty/greasy and contained white matter around the inside and outside as well as hair and what appeared to be dried skin particles. Surveyor interviewed R1 who was unsure if staff cleaned the mask. R1's medical record contained the following physician orders:~ BiPAP with oxygen at night and during naps (fill with water). ~ Humidified oxygen at 2 liters with rest and 3 liters with activity at all times. Surveyor noted R1's care plan and Treatment Administration Record (TAR) did not contain any other orders or instructions for care of the BiPAP machine or supplies.On [DATE] at 9:19 AM, Surveyor again interviewed R1 who was not sure who cleaned the BiPAP machine or supplies and hadn't seen anyone do so. R1 could not recall the last time the mask was cleaned and stated the mask was really dirty. Surveyor noted the mask was in the same unclean condition as previous observations. R1 indicated nursing staff fill the machine with water. 2. On [DATE], Surveyor reviewed R5's medical record. R5 had a diagnosis of OSA. R5's MDS assessment, dated [DATE], had a BIMS score of 15 out of 15 which indicated R5 had intact cognition. R5 was R5's own decision maker. On 12/125 at 9:11 AM, Surveyor interviewed R5 who indicated staff do not clean R5's CPAP machine and R5 could not complete the task independently. Surveyor noted R5 had a CPAP machine with nasal mask. The mask appeared greasy and contained what appeared to be white, flaky, skin particles. The CPAP filter was black and contained dust-like particles on the filter and inside the filter cabinet. On [DATE] at 11:00 AM, Surveyor interviewed R5 who indicated R5 rinsed the tubing and mask at home but did not think nursing staff had done so since R5 was admitted . Surveyor noted the mask and filter were in the same condition as previously observed on [DATE].Surveyor noted R5's medical record did not contain orders for cleaning the CPAP machine, mask, tubing, or filter. On [DATE] at 9:27 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-C who indicated nurses are required to clean CPAP machines. CNA-C indicated CNAs are not responsible for cleaning or maintaining CPAP or BiPAP machines. On [DATE] at 9:33 AM, Surveyor interviewed Director of Nursing (DON)-B who confirmed Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) are required to clean all CPAP and BiPAP machine filters, tubes, and masks for residents. DON-B indicated residents who have CPAP or BiPAP machines have cleaning orders on their TAR. DON-B was not aware that R1 and R5's TARs did not include instructions for care and wasn't aware the machines/parts were not cleaned per manufacturer's recommendations and the facility's policy. On [DATE] at 12:35 PM, DON-B approached Surveyor and confirmed R1 and R5's masks were not cleaned and their TARs did not contain instructions or orders to clean the machines, masks, tubing, or filters.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility did not maintain an infection prevention and control program designed to prevent the development and transmission of communicable disease and infection for 3 residents (R) (R42, R11, and R1) of 16 sampled residents. R42 was on droplet precautions. Staff provided care for R42 without wearing personal protective equipment (PPE).R11 was on contact precautions. Staff provided care for R11 without wearing PPE. R1 had a diagnosis of pneumonia. R1 was not listed on the facility's infection control resident line list for surveillance. Findings include:The facility's Infection Prevention and Control Program policy, revised 1/1/25, indicates: .4. The Infection Prevention Committee (ICP) will make recommendations about how to best maintain a safe, sanitary, and comfortable environment for residents and staff and how to prevent the development and transmission of disease and infection .11. All residents on transmission precautions (contact, droplet, airborne) will be clinically reviewed by the Registered Nurse (RN) Manager or Director of Nursing (DON)/Infection Preventionist (IP). The appropriate care plan will be developed and communicated to all other department with a need to know .The facility's Infection Control Surveillance, Documentation, Monitoring, and Data Analysis policy, revised 1/1/25, indicates: .c. This process consists of collecting/documenting on individual cases and comparing the collected data to standard written definitions of infections as outlined in McGeer's Definition of Infection .d. The licensed staff evaluates the appropriate use of antibiotics in addition to evaluating prudent use of antibiotics .4. Data Analysis: a. Data analysis includes the following elements on each infection to detect clusters and trends: type of infection; date of onset; location in facility; and appropriate lab information .1. On 12/1/25, Surveyor reviewed R42's medical record. R42 was admitted to the facility on [DATE] and had diagnoses including quadriplegia C1-C4, spondylosis, and anxiety. R42's Minimum Data Set (MDS) assessment, dated 10/10/25, had a Brief Interview for Mental Status (BIMS) score of 5 out of 15 which indicated R42 had severe cognitive impairment. R42 had an activated Power of Attorney for Healthcare (POAHC). R42's medical record indicated R42 was diagnosed with pneumonia on 10/18/25. Surveyor observed a droplet precautions sign posted outside R42's room and a PPE cart near the door.On 12/1/25 at 9:53 AM, Surveyor observed Certified Nursing Assistant (CNA)-E enter R42's room without wearing PPE. CNA-E spoke with R42, removed food items from the bedside table, retrieved items for R42, and walked out of the room with a breakfast tray. On 12/1/25 at 9:58 AM, Surveyor interviewed CNA-E who indicated R42 was no longer on droplet precautions and PPE was not necessary. On 12/2/25 at 11:40 AM, Surveyor observed CNA-G in R42's room without PPE. CNA-G adjusted R42's pillow cases, linens, and items on R42's bedside table. CNA-G sanitized hands prior to leaving the room. On 12/2/25 at 11:45 AM, Surveyor interviewed CNA-G who indicated staff only have to wear PPE when emptying R42's Foley catheter and can't apply PPE every time they enter the room. 2. On 12/1/25, Surveyor reviewed R11's medical record. R11 was admitted to the facility on [DATE] and had diagnoses including Parkinson's disease, epilepsy, falls, and urinary tract infection (UTI). R11's MDS assessment, dated 10/26/25, had a BIMS score of 9 out of 15 which indicated R11 had moderate cognitive impairment. R11 had an activated POAHC. R11's medical record indicated R11 was diagnosed with a UTI on 10/15/25. Surveyor observed a contact precautions sign posted outside R11's room and a PPE cart near the door.On 12/1/25 at 10:09 AM, Surveyor observed CNA-E enter R11's without donning PPE to adjust the call light. On 12/1/25 at 10:12 AM, Surveyor interviewed CNA-E who indicated staff do not have to don a gown and gloves unless they provide direct care to R11. On 12/1/25 at 10:30 AM, Surveyor observed Housekeeper (HK)-H clean R11's room without wearing PPE. On 12/1/25 at 10:32 AM, Surveyor interviewed HK-H who indicated PPE use is based on the type of precautions. HK-H indicated HK-H only wears gloves when vacuuming and had worn a gown and gloves while cleaning the toilet but took them off. On 12/2/25 at 1:15 PM, Surveyor interviewed Director of Nursing (DON)-B and Nurse Manager (NM)-I. NM-I indicated staff should wear (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PPE for all resident cares for those on contact precautions and staff should apply PPE for all situations when entering the room of a resident on droplet precautions. NM-I indicated staff are expected to follow precautions signs posted outside resident rooms. On 12/2/25 at 2:34 PM, Surveyor again interviewed NM-I who indicated R11 was currently on a supplement for preventative UTI management. NM-I indicated R11 had two UTIs in September and one on 10/15/25 which is why R11 was on contact precautions. 3. On 12/1/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including dementia, acute and chronic respiratory failure, and chronic obstructive pulmonary disease (COPD). R1's MDS assessment, dated 9/4/25, had a BIMS score of 6 out of 15 which indicated R1 had severe cognitive impairment. R1 had a Guardian for healthcare decisions. On 12/2/25, Surveyor reviewed the facility's infection prevention surveillance resident line lists. R1 was not on the line list for surveillance despite a pneumonia diagnosis on 8/27/25 for which R1 was treated with antibiotics.On 12/3/25 at 1:59 PM, Surveyor interviewed DON-B who indicated a pneumonia diagnosis should be documented on the facility's surveillance line list. DON-B verified staff did not add R1 to line list for a pneumonia diagnosis on 8/27/25.