STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525714	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neighbors - West Neighborhood (the)	651 Howison Circle Menomonie, WI 54751

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, a resident's medication order was not limited to 14 days, and prescribing practitioner did not document the rationale for the extended time use or a specific duration for use for 1 of 3 sampled residents, (R) R15, reviewed for PRN (as needed) psychotropic medications. R15 was prescribed PRN lorazepam for anxiety on 02/27/2026; there was no rationale for extended use written and no specific duration for use. This is evidenced by: R15 was admitted to the facility on [DATE] and has diagnoses that include vascular dementia with agitation and anxiety. R15's physician order dated 02/27/26 states: lorazepam - Schedule IVtablet; 0.5 mg; amt: 0.25mg; oral, Special Instructions: anxiety AEB (as evidenced by) frightened facial expr;verbal statements; Monitor response and consider alternative if ineffective. Every 4 Hours - PRN, PRN 1, PRN 2, PRN 3, PRN 4, PRN 5, PRN 6 - Open ended date. Review of R15's medication administration record (MAR) revealed R15 used lorazepam 0.25mg for anxiety on 02/27/26, 02/28/26, 03/01/26, 03/02/26, 03/04/26, 03/06/26, 03/07/26, and 03/09/26. Surveyor reviewed R15's medical record and was unable to locate a rationale for the extended use for the PRN lorazepam and did not locate a specific duration for its use. On 03/19/26 at 1:55 PM, Surveyor interviewed Director of Nursing (DON) B about R15's PRN lorazepam order greater than 14 days with no end date or rationale for continued use. DON B stated the facility works with hospice and tries not to have PRN psychotropic medications. This order was missed getting the continued order.

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 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, interview and record review, the facility did not ensure the resident environment remains free of accident hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents for 2 of 3 residents (R)(R11 and R35) reviewed.R11 and R35 had fallen; the facility did not initiate immediate intervention to prevent future falls, investigate the root cause of the fall and review and revise care plan fall interventions.This is evidenced by:Facility policy titled, Fall Risk Program, with a reviewed date of 03/04/25, states in part: POLICY: This program emphasizes assessment, identification, and intervention of resident falls, utilizing the least restrictive method to keep the resident safe. The program identifies the factors that place residents at risk for falls, promotes proactive healthcare practices for resident care planning, and identifies the main components of an effective fall prevention program. These components are fall risk assessment, interventions, documentation, and regular reassessment and evaluation. PROCEDURE: A. Prevention 2. All residents identified to be at risk for fall will have care plans and master assignment sheets that reflect risk status. a. Residents who score 10 or above are considered High Risk for falls and it will be documented on the MAS as DO NOT leave on toilet alone. 4. Falls will be discussed at the morning meeting to ensure all departments are aware of safety needs and interventions are put into place to prevent further falls if appropriate. 5. Residents who experience multiple falls will be assessed for trends and reviewed by DON, MD/provider and pharmacy consultant as needed.Example 1R11 was admitted to the facility on [DATE] with pertinent diagnoses of Parkinsonism, anxiety disorder, and age-related osteoporosis.R11's quarterly Minimum Data Set (MDS) assessment, dated 03/02/26, noted a Brief Interview of Mental Status (BIMS) score of 11, indicating moderately impaired cognition. R11 has impaired range of motion (ROM) on both upper extremities and impaired ROM on one side of lower extremities. R11 requires substantial/maximal assistance with all Activities of Daily Living (ADL). R11 had one fall with major injury.R11's care plan, dated 09/04/25, with a target date of 06/10/26, states: [R11] has potential for injury/falls related to Parkinsonism and history of falls with a goal to have no serious injuries through target date. Interventions include: Fall risk assessment and physical device assessments on admission, quarterly, with significant changes in condition and after a fall. Follow facility policy/procedure for falls and incidents. Investigate cause of fall/incident and review risk factors as appropriate.R11's fall risk assessments:05/27/25 Score: 10: > or = to 10 But can make own decisions, [NAME] on MAS May leave on toilet alone, and rationale is: independent for toileting.08/26/25 Score 12 (high risk): > or = to 10 But can make own decisions, [NAME] on MAS May leave on toilet alone, and rationale is: calls for staff when finished.02/25/26 Score 19 (high risk): > or = to 10 But can make own decisions, [NAME] on MAS May leave on toilet alone, and rationale is: responsible for self.Surveyor reviewed R11's fall investigations:On 01/28/26 at 3:05 PM, R11 had an unwitnessed fall in room. Staff found R11 lying on floor in room. No injuries were assessed at that time. On 01/29/26 at approximately 2:00 AM, R11 reported 8/10 pain in right wrist. Nurse observed R11's right wrist to be swollen and bruised. Provider was notified and R11 was transferred to local hospital for evaluation. R11 returned to facility on the same day with a diagnosis of right radius fracture. Facility investigated R11's fall and noted root cause to be R11 self-transferring without assist. No new safety interventions were implemented to prevent falls and care plan was not updated.On 03/19/26 at 12:19 PM, Surveyor interviewed Director of Nursing (DON) B regarding R11's fall. DON B stated after reviewing the fall, appropriate safety interventions were in place and no changes to the care plan were needed.Example 2R35 was admitted to the facility on [DATE] with pertinent diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, unspecified dementia with agitation anxiety and mood disorder, major depressive disorder, insomnia, polyneuropathy, overactive bladder.R35's quarterly MDS, dated [DATE], noted a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	BIMS score of 10, indicating moderately impaired cognition. R35 requires substantial/maximal assist with lying to sitting and transfers; partial/moderate assist with rolling left to right, sitting to lying and sit to stand. R35 had two or falls with no injury.R35's care plan, dated 12/09/25, with a target date of 06/10/25, states: [R35] has a potential for injury/falls related to fall risk assessment score of 19, periods of confusion, and limited/decreased mobility with a goal of no serious injuries. Interventions include: Fall risk assessment and physical device assessments on admission, quarterly, with significant changes in condition and after a fall. Follow facility policy/procedure for falls and incidents. Investigate cause of fall/incident and review risk factors as appropriate. Remind of need for assist and safety interventions as needed. Do not leave alone on toilet. Low bed. Mat on floor. Hourly safety checks when in bed. Encourage to sleep in bed, discourage recliner. 30 minute safety checks at night.R35's fall risk assessments:11/28/25 : Score 13 (high risk) > or = to 10 But can make own decisions, [NAME] on MAS May leave on toilet alone, and rationale is - Aware of limitations.12/01/25 19 (high risk): > or = to 10 But can make own decisions, [NAME] on MAS May leave on toilet alone, and rationale is - Responsible for self.02/28/26 15 (high risk): > or = to 10: [NAME] on MAS as Do Not Leave on toilet alone. Resident not safe. Needs assistance with task, fall history, [NAME] steady used for transfers.Surveyor reviewed R35's fall investigations:On 12/02/25 at 8:45 PM, R35 had unwitnessed fall in room. R35 found seated on floor mattress at bedside. No injuries. Provider notified. Root cause: presumed R35 was reaching for something and slid off side of bed. New safety interventions: place personal items and call cord within reach. Care plan updated.On 12/13/25 at 4:35 AM, R35 had unwitnessed fall in room. CNA answered R35's call light and found R35 sitting on floor mat. R35 stated she crawled out of bed to look under it for her catheter bag and just ?slid out of bed.' No injuries. Provider notified. Root cause: slid out of bed. New safety interventions: hourly safety checks when in bed. Care plan updated.On 01/01/26 at 2:35 AM, R35 had unwitnessed fall in room. CNA answered R35's call light and found R35 sitting on floor in front of recliner on floor mat. Recliner legs noted to be partially lowered. R35 did not provide answer for how fall occurred. No injuries noted. Provider notified. Root cause: cognitive decline and dementia, poor decision making, and failed to self-transfer. New safety interventions: R35 not to sleep in recliner. Care plan updated.-Of note: no documentation of recliner/equipment assessed for safety and/or functioning.On 01/04/26 at 6:00 AM, R35 had unwitnessed fall in room. CNA entered room and found R35 seated upright on floor mattress. R35 stated she thought she slipped off side of bed and woke up sitting there on floor. No injuries noted. Provider notified. R35 re-educated on calling for assistance. Root cause: R35 slid off bed.-Of note: no new safety interventions implemented. No documentation of bed/equipment assessed for safety and/or functioning.On 03/09/26 at 1:30 AM, R35 had unwitnessed fall in room. CNA entered R35's room after hearing R35 calling out for help. R35 found sitting on fall mat next to bed. R35 stated she couldn't sleep and thought she might be able to in the recliner. R35 stated she slid out of bed. No injuries. R35 re-educated of fall safety. Provider notified. Root cause: slid out of bed.-Of note: no new safety interventions implemented. No documentation of bed/equipment assessed for safety and/or functioning.On 03/09/26 at 9:45 PM, R35 had unwitnessed fall in room. Staff found R35 sitting on floor mat next to bed. R35 stated she thought she dropped a piece of paper. No injuries. Provider notified. R35 re-educated on fall safety. Root cause: leaning too far over edge and slipped off disposable chuck pad on bed. New safety intervention: do not use disposable chucks on bed. Care plan updated.On 03/15/26 at 3:00 AM, R35 had unwitnessed fall in room. CNA heard R35 call out for help and found R35 sitting on floor mat next to bed. R35 stated she slid off bed. No injuries. Provider notified. Root cause: slid off bed.-Of note: no new safety interventions implemented. No documentation of bed/equipment assessed for safety and/or functioning.On 03/19/26 at 12:13 PM, Surveyor interviewed DON B regarding R35's falls. DON B stated that all of R35's falls were investigated and appropriate safety interventions were already in place and effective. DON B stated that no new safety interventions were necessary for R35 because the facility is not responsible for preventing falls, but to prevent injuries and R35 had not sustained any injuries from any falls.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not adequately assess and provide necessary care and services to attain or maintain the highest practicable physical wellbeing for 1 of 1 resident (R)(R37) reviewed for pain management. R37 did not have an individualized pain assessment completed to monitor, assess, and evaluate for efficacy for pain management and non-pharmacological interventions were not implemented.This is evidenced by:Facility policy titled, Pain Management, with a reviewed date of 04/13/25, states in part: POLICY: Control of resident's pain is integral to the mission statement of the facility; Nursing will set a high priority on pain management and pain control. Pain will be assessed, treated, and evaluated for effectiveness whenever a resident experiences pain, whether chronic, breakthrough or acute. Upon admission, all residents will be assessed for the presence of pain. The appropriate pain scale will be used to rate the pain. The health care team will collaborate with resident and family to set realistic goals and limitations for pain management. Pharmacological as well as non-pharmacological measures will be implemented to ensure that the resident's pain is appropriately managed. Specific measures that have been determined to be effective for individual residents will be incorporated into the care plan if appropriate. PROCEDURE: 1. The nurse will complete a Pain Management-Pain Observation on admission, quarterly, and if new pain diagnosis presents. 2. If pain is present, pain will be re-assessed using pain scale and recorded on the MAR Pain Flow Sheet, and Nurses notes, if appropriate: A. whenever a resident has a new risk factor for pain; B. whenever a resident complains of pain or exhibits nonverbal signs of pain; C. whenever a resident is administered a PRN pain medication; D. at least daily for residents on regularly scheduled pain meds; weekly for residents stable in a pain management program.4. Pain is quantified using the appropriate pain scale: a. Verbal score of 0-10; b. Wong-Baker face scale; c. PAINAD scale.R37 was admitted to the facility on [DATE] with pertinent dx of Parkinsonism, panic disorder, disorientation, generalized anxiety disorder, polyneuropathy, intervertebral disc degeneration lumbar region with discogenic back pain, presence of brain stimulator implant.R37's admission Minimum Data Set (MDS) assessment, dated 02/13/26, noted a Brief Interview for Mental Status (BIMS) score of 13/15, indicating cognition intact. R37 received scheduled pain medication. R35's pain assessment interview noted pain is present and frequently effects sleep. R37 noted a pain score of 4/10 as the worst pain.R37's care plan, dated 02/24/26, with a target date of 05/24/26, states: [R37] has potential for pain/discomfort related to right shoulder with a goal of [R37] will verbalize or score relief of pain/discomfort of <6. Interventions include: Administer pain relief measures as identified on the MAR. Evaluate and document effectiveness on MAR pain flow sheet and summarize in nursing notes as appropriate. Review the continued need for any routine administration of medication and adjust or discontinue as appropriate. Use appropriate pain scales: A. 0-10 scale. B. Wong-Baker scale. C. PAINAD scale as identified on pain assessment/pain flow sheet for the following situations: pain assessments with vital signs, daily for residents on regularly scheduled pain medications, weekly per policy/procedure and as needed. Provide non-therapeutic interventions as needed.R37's provider orders:02/06/26 Weekly pain assessment.02/06/26 acetaminophen 650 mg for pain/back ache every 6 hours as needed.02/06/26 meloxicam 15 mg for right shoulder pain once daily.02/06/26 Muscle Rub (methyl salicylate-menthol) cream topical as needed.02/06/26 tramadol (narcotic pain med) 25 mg for pain three times a day as needed.02/06/26 Voltaren Arthritis Pain (diclofenac sodium) gel topical for right shoulder pain three times a day.02/06/26 Apply ice/cold compress to right shoulder for pain/swelling fluid build up three times a day as needed.02/23/26 Muscle Rub (methyl salicylate-menthol) cream topical for right shoulder four times a day.-Of note: as needed (PRN) medications did not include clear parameters or indication of when to use each one.Surveyor reviewed R37's MAR and noted the following PRN administrations:02/07/26 - Acetaminophen 5:44 AM Reason: pain; Tramadol 5:44 AM Reason: right shoulder pain-Severity and characteristics of pain not (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented.02/09/26 - Tramadol 4:36 AM Reason: right shoulder pain-Severity and characteristics of pain not documented.02/13/26 - Tramadol 9:32 AM Reason: right shoulder-Severity and characteristics of pain not documented.02/14/26 - Acetaminophen 7:59 PM Reason: right side hip pain-Severity and characteristics of pain not documented. First time documenting this area for pain; no documentation of notifying provider of new pain.02/15/26 - Acetaminophen 5:42 AM Reason: right lower rib pain-Severity and characteristics of pain not documented. First time documenting this area for pain; no documentation of notifying provider of new pain.02/16/26 - Acetaminophen 6:00 AM Reason: right lower quadrant pain-Severity and characteristics of pain not documented. First time documenting this area for pain; no documentation of notifying provider of new pain.02/17/26 - Acetaminophen 7:55 PM Reason: pain-No location, severity, or characteristic of pain documented.02/18/26 - Tramadol 1:41 AM Reason: back pain-No location, severity, or characteristic of pain documented.02/21/26 - Acetaminophen 8:56 PM Reason: pain-No location, severity, or characteristic of pain documented.02/22/26 - Acetaminophen 7:37 AM/11:17 PM Reason: right shoulder pain-Severity and characteristics of pain not documented.02/25/26 - Acetaminophen 8:06 PM Reason: back pain-No location, severity, or characteristic of pain documented.02/26/26 - Acetaminophen 11:17 AM/11:43 PM Reason: back pain; Tramadol 11:17 AM Reason: right shoulder-Severity and characteristics of pain not documented.02/27/26 - Acetaminophen 6:17 AM Reason: pain; Tramadol 4:01 PM Reason: pain-No location, severity, or characteristic of pain documented.02/28/26 - Tramadol 12:47 PM Reason: pain-No location, severity, or characteristic of pain documented.03/02/26 - Acetaminophen 10:21 PM Reason: pain-No location, severity, or characteristic of pain documented.03/03/26 - Acetaminophen 8:35 PM Reason: pain-No location, severity, or characteristic of pain documented.03/05/26 - Acetaminophen 7:46 AM Reason: bilateral arm pain- Severity and characteristics of pain not documented.03/06/26 - Acetaminophen 8:43 PM Reason: pain-No location, severity, or characteristic of pain documented.03/07/26 - Acetaminophen 4:22 AM/3:57 PM Reason: backache-No location, severity, or characteristic of pain documented.03/11/26 - Acetaminophen 9:18 PM Reason: pain-No location, severity, or characteristic of pain documented.03/16/26 - Acetaminophen 12:35 AM Reason: shoulder pain-No specific location, severity, or characteristic of pain documented.03/17/26 - Acetaminophen 12:54 AM/8:08 PM Reason: pain-No location, severity, or characteristic of pain documented.Of note: follow-up PRN pain assessments did not include intensity, severity or characteristics of pain. R37's non-pharmacological intervention of ice/cold compress was not administered at any time between 02/06/26 - 03/19/26.Review of R37's MAR of scheduled pain meds noted Voltaren pain gel was documented as refused on: 02/07/26, 02/10/26, 02/13/26 - 02/16/26, 02/18/26 - 02/25/26, 02/27/26 - 03/05/26, 03/08/26, 03/10/26 - 03/14/26, 03/18/26, and 03/19/26. No documentation of notifying provider of medication refusal was noted. No pain assessment or alternative interventions were noted with refusals.On 03/19/26 at 9:00 AM, Surveyor interviewed Registered Nurse (RN) C regarding pain assessments. RN C stated that typically a pain score would be documented in the MAR if there is an order to do so. Otherwise, a comment box will pop-up and this would be where the nurse enters a pain score. Surveyor asked RN C if location and characteristic of pain is assessed and documented. RN C stated no, not typically, but it depends on the nurse. Surveyor asked RN C how a resident's pain would be monitored for changes or worsening if this wasn't assessed. RN C stated being unsure and that it would be a good idea to do that. Surveyor asked RN C how a nurse decides which PRN medication to give if there are multiple options. RN C stated that it would either be the up to the nurse or whatever the resident states they prefer to take. RN C stated not being aware of any particular standard to follow on which PRN to give when or if there was a specific hierarchy for opioid or non-opioid. Surveyor asked RN C why R37's non-pharmacological pain interventions had not been administered. RN C stated that he wasn't aware there was a non-pharmacological intervention ordered.On 03/19/26 at 11:25 AM, Surveyor interviewed Medical Doctor (MD) F regarding as needed medications. MD F stated that the expectation would be for nursing staff to administer narcotic (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications for breakthrough pain when scheduled pain meds are also ordered. MD F stated the expectation would be for the nurse to administer non-opioid meds first, evaluate efficacy, and then determine if opioid med should be used.On 03/19/26 at 12:03 PM, Surveyor interviewed Director of Nursing (DON) B regarding pain assessments. DON B stated that pain assessments should usually include a pain score or use of a pain face scale, depending on cognition. If staff don't have an option to choose a score, a note should be entered with administration of a PRN med indicating location and severity of pain. Surveyor asked DON B how nurses determine which PRN med to give if the order does not include parameters. DON B stated that it would be expected to do non-pharmacological interventions first, then try non-opioid, and if these options are ineffective will try opioid. Surveyor asked DON B if the provider should be notified when a resident refuses scheduled pain meds. DON B stated yes so that it can also be assessed to see if that med should be discontinued as it would likely be unnecessary. Surveyor showed DON B R37's MAR and the refusals documented of the scheduled Voltaren. DON B stated she was unaware of this and that the nurses should have informed her.

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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, interview, and record review, the facility did not establish 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 3 of 4 residents (R5, R1, and R31) observed for proper hand hygiene during cares. Findings: Facility policy titled, Hand Washing, Hand Hygiene reviewed 9/19/2025 stated in part: .Examples of hand hygiene moments: Before touching a resident, before clean/aseptic procedures, after body fluid exposure risk, after touching a resident, after touching a resident's surroundings, before and after utilizing gloves .Example 1 R5 was admitted to the facility on [DATE] with a Brief Interview of Mental Status (BIMS) score of 15/15, which indicated R5 was cognitively intact. R5 had a diagnosis of acute cystitis with sepsis (a medical emergency where a bladder infection spreads into the bloodstream, causing a severe systemic response). On 03/18/26 at 8:16 AM, Surveyor observed Certified Nursing Assistant (CNA) D perform morning cares with R5. CNA D performed proper hand hygiene when entering R5's room and put on proper Personal Protective Equipment (PPE) for Enhanced Barrier Precautions (EBP). CNA D took out clothes from R5's closet, touching cabinet doors with gloved hands, and filled water basin in sink in R5's bathroom. CNA D then removed R5's gripper socks, then put clean compression socks and blue gripper socks over R5's compression socks. CNA D provided R5 with a wet washcloth to wash R5's face. CNA D then went into R5's top drawer for R5's bra. CNA D cleaned R5's back, front torso, under R5's armpits, under breasts and abdominal folds. CNA D applied lotion to R5's back and arms. CNA D removed soiled gloves and put on clean gloves without performing any hand hygiene. CNA D applied a medicated powder under R5's breasts bilaterally. CNA D then removed soiled gloves and again performed no hand hygiene before putting on clean gloves. CNA D then continued cares with no concern with the rest of the observation. On 03/19/26 at 9:45 AM, Surveyor informed Director of Nursing (DON) B of observation made during cares. DON B replied, She really should've performed hand hygiene in between glove changes. Example 2 R1 was admitted to the facility on [DATE] with a BIMS of 15/15 which indicated R1 was cognitively intact. R1 had a diagnosis of urine retention. On 03/19/26 at 8:44 AM, Surveyor observed CNA E perform urinary catheter care to R1. CNA put on PPE for EBP and gathered supplies to clean R1. CNA E cleaned R1's upper body. CNA E handed R1 the deodorant. CNA E assisted R1 to roll onto R1's left side, and CNA E then washed R1's back. CNA E assisted R1 to roll onto her back and helped R1 put on a purple sweatshirt. CNA E removed R1's pressure relieving boots to both feet. CNA E then removed soiled gloves and put on new gloves with no hand hygiene performed between the glove changes. CNA E placed a disposable attend on the floor next to R1's bed and placed a graduate on the attends. Surveyor observed CNA E emptying R1's catheter. There were no concerns with the rest of the observation. (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	On 03/19/26 at 9:45 AM, Surveyor informed DON B of the observation made during cares. DON B replied, She should've performed hand hygiene in between glove changes. Example 3 R31 was admitted to the facility on [DATE] and current diagnoses include dementia and rheumatoid arthritis. R31 is dependent on staff for personal hygiene. On 03/19/2026 at 8:55 AM, Surveyor observed CNA G provide R31 morning cares. CNA G sanitized hands, entered R31's room, and gathered R31's clothes, washcloth and basin of water. CNA G applied gloves and applied socks and pants on R31. CNA G washed and dried R31's eyes. CNA G did not wash R31's hands. CNA G removed R31's brief and washed peri area appropriately and rolled R31 to side and washed buttocks and anal area appropriately. CNA G did not remove gloves and applied clean brief on R31. CNA G removed gloves and did not complete hand hygiene. CNA G assisted R31 to sit at edge of bed. With contaminated hands CNA G moved the [NAME] steady lift in front of R31 and put gait belt on R31. CNA G assisted R31 to stand and pulled up pants and transferred to wheelchair. CNA G with contaminated hands applied slippers on R31's feet. CNA G with contaminated hands brushed R31's hair. Then CNA G sanitized her hands and brought R31 to the dining room. When in the dining room CNA G did not offer hand hygiene to R31 before breakfast was provided. On 03/19/2026 at 1:05 PM, Surveyor interviewed CNA G asking about hand hygiene with R31's cares. CNA G stated they did not complete hand hygiene when gloves were removed and should have sanitized R31's hands before eating. On 03/19/2026 at 1:32 PM, Surveyor interviewed DON B about hand hygiene with cares. Surveyor reviewed with DON B of the observation with CNA G. DON B stated the staff had just done training on hand hygiene.