

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2025
NAME OF PROVIDER OR SUPPLIER Lakewest Rehabilitation and Skilled Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2450 Bickers St Dallas, TX 75212	

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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46403</p> <p>Based on observation, record review and interview, the facility failed ensure a resident received care, consistent with professional standards of practice, to prevent pressure ulcers from developing for 4 (Resident #2, Resident#3, Resident#4 and Resident#5) of 5 residents reviewed for pressure ulcers.</p> <p>The facility failed to ensure Resident#2's pressure relieving mattress functioned properly on 03/20/25.</p> <p>The facility failed to have pressure relieving mattress set to the correct weight settings for Resident #3's, Resident#4, and Resident#5 to prevent pressure ulcers or skin breakdown on 03/20/2025 and 03/21/25.</p> <p>These failures could affect residents at risk for pressure ulcers of developing new or worsening existing pressure ulcers.</p> <p>Findings included:</p> <p>Record review of Resident #2's face sheet, dated 03/21/25, reflected a [AGE] year-old female, with an initial admitted [DATE], and a re-admitted [DATE]. Resident #2 had diagnoses of disorder of the skin and subcutaneous tissue unspecified, local infection of the skin and subcutaneous tissue, low back pain, other abnormalities of gait and mobility and generalized muscle weakness.</p> <p>Record review of Resident #2's Quarterly MDS Assessment, dated 02/06/25, reflected Resident #2 had a BIMS score of 08, which meant Resident #2 had a moderate level of cognition. The MDS also reflected under skin conditions that Resident#2 was at risk of developing pressure ulcers. Resident#2's treatments included pressure reducing device for bed.</p> <p>Record review of Resident# 2's Care plan, revised 02/12/25 reflected Resident#2 was at risk of skin break down related to incontinence. Resident#2 's goals reflected she will remain free of pressure injury through the review date. Resident#2's intervention included pressure relieving mattress.</p> <p>Record review of Resident#2's physician orders, dated 03/21/25, reflected low air mattress. Nurse to check for proper functioning every shift.</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 03/20/25 at 8:00 AM revealed Resident#2 had a pressure relieving mattress, and the bed was beeping and set to static.</p> <p>Interview on 03/20/25 at 8:10 AM LVN D stated she would need to contact hospice about the bed beeping. LVN D stated someone may have brushed against the bed and caused the machine to start beeping. LVN D stated if the machine is set to static the air mattress is not doing its job and circulating the air to help improve pressure wounds.</p> <p>Interview on 03/20/25 at 8:45 AM CNA B stated she did not touch Resident#2 bed and did not know what static meant and why it was beeping. CNA B stated she would let the charge nurse know that Resident#2 bed was beeping.</p> <p>Observation on 03/21/25 at 11:55 AM revealed RA C weighed Resident#2 in the Hoyer lift with assistance, and she weighed 101.06.</p> <p>Attempted to interview Resident#2 on 03/21/25 at 11:57 AM and Resident#2 was not interview able at this time.</p> <p>Record review of Resident #3's face sheet dated 03/21/25, reflected a [AGE] year-old female, with an initial admitted [DATE], and a re-admitted [DATE] and 05/30/25. Resident #3 had diagnoses of disorder of hemorrhage of anus and rectum, pain unspecified, non-pressure chronic ulcer of skin of other sites unspecified severity, pressure ulcer of right heel, stage 3 and generalized edema.</p> <p>Record review of Resident #3's Quarterly MDS Assessment, dated 02/25/25, reflected Resident #3 had a BIMS score of 03, which meant Resident #3 had a low level of cognition. The MDS also reflected under skin conditions that Resident#3 entered the facility with a stage 4 pressure ulcer. Resident#3 was at risk of developing pressure ulcers. Resident#3's treatment included pressure reducing device for bed.</p> <p>Record review of Resident# 3's Care plan, revised 09/09/24 reflected Resident#3 was at risk of skin break down related to decubitus ulcers/ pressure ulcers incontinence and current pressure ulcers. Resident#3 's goals reflected she will remain free of pressure injury through the review date. Resident#3's intervention included pressure relieving mattress (air mattress).</p> <p>Record review of Resident#3's Physician orders dated 05/30/24 reflected, low air loss mattress. Nurse to check for proper functioning every shift. Every shift for wound healing to promote wound healing.</p> <p>Observation on 03/20/25 at 8:15 AM revealed Resident#3 pressure relieving bed weight was set to 80.</p> <p>Observation on 03/21/25 at 11:48 AM revealed RA C weighed Resident#3 in the Hoyer lift with assistance, and she weighed 100.8,</p> <p>Attempted to interview Resident#3 on 03/21/25 at 11:49 AM and Resident#4 was not interview able at this time</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #4's face sheet dated 03/20/25 reflected a [AGE] year-old female, with an initial admitted [DATE], and a re-admitted [DATE]. Resident #4 had diagnoses of paraplegia, unspecified, pressure ulcer of sacral region, stage 4, generalized muscle weakness, and other chronic pain.</p> <p>Record review of Resident #4's Quarterly MDS Assessment, dated 02/25/25, reflected Resident #4 had a BIMS score of 03, which meant Resident #4 had a low level of cognition. The MDS also reflected under skin conditions that Resident#4 entered the facility with a stage 4 pressure ulcer. Resident#4 was at risk of developing pressure ulcers. Resident#4's treatment included pressure reducing device for bed.</p> <p>Record review of Resident# 4's Care plan, revised 11/01/24 reflected Resident#4 had a stage 4 pressure sacrum related to diabetes, paraplegia, bowel incontinence, deconditioning neuropathy, and refusal of aspects of care. Resident#4's goals reflected her wound would show no signs of infection. Resident#4's intervention included low air loss mattress .</p> <p>Record review of Resident#4 physician order, dated 12/20/24, reflected Low air mattress. Nurse to check for proper functioning every shift. Every shift for wound healing to promote wound healing.</p> <p>Observation on 03/20/25 at 8:20 AM revealed Resident#4 pressure relieving bed weight was set to 180.</p> <p>Interview on 03/20/25 at 9:00 AM Resident#4 stated she felt like there was a hole in her bed and it was very uncomfortable. Resident#4 stated she felt like she needed a bigger bed and more space.</p> <p>Interview on 03/20/25 at 9:15 AM LVN A stated she had just returned from vacation and was not sure about the bed weight settings.</p> <p>Observation and interview on 03/21/25 at 11:40 AM RA C weighted Resident#4 in the Hoyer lift with assistance and she weighed 247.2 pounds. RA C stated that she does weekly weights on the residents, and she used this specific Hoyer because it had the scale connected to it.</p> <p>Record review of Resident #5's face sheet dated 03/21/25 reflected a [AGE] year-old male, with an initial admitted [DATE] and a re-admitted [DATE]. Resident #5 had diagnoses of Pressure ulcer of sacral region, unspecified stage, type 2 diabetes mellitus with hyperglycemia, and muscle weakness.</p> <p>Record review of Resident#5's quarterly MDS Assessment, dated Resident #5 had a BIMS score of 11, which meant Resident #5 had a moderate level of cognition. The MDS also reflected under skin conditions that Resident#5 was at risk of developing pressure ulcers. Resident#5's treatment included pressure reducing device for bed.</p> <p>Record review of Resident# 5s Care plan, undated reflected Resident#5 was at risk of skin break down related to decrease mobility, history of ulcers, and incontinence. Resident#5's goals reflected Resident#5 would remain free from pressure injury through the next review date. Resident#5's interventions included pressure relieving mattress.</p> <p>Record review of Resident#5's weights reflected he weighed 144.2 on 03/10/25.</p> <p>Record review of Resident#5's orders reflected no active orders for pressure relieving mattress.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 03/20/25 at 8:30 AM revealed Resident#5 pressure relieving mattress weight was set to 450.</p> <p>Resident#5 was not available to weigh on 03/21/25.</p> <p>Interview on 03/21/25 at 5:45 PM, the Administrator and the interim director of nursing stated the nursing staff were responsible for checking the resident's beds to ensure they were set appropriately to the residents' weights and not in static mode. The Administrator and interim director stated that mattress not set appropriately could cause residents to have pressure wounds and not assist with the healing process. The interim director of nursing stated each bed had a margin on how the weight can vary on each bed. The interim director of nursing stated the nursing managers will be responsible for training the nursing staff on how the pressure relieving mattress work. The interim director of Nursing stated she had been in the facility for two weeks and the Administrator started three days ago and the DON would start approximately next week.</p> <p>Record review of facility policy titled Pressure Ulcer/Skin Injury Management and Prevention, dated 01/08/23 reflected, Policy: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries .6. The physician will authorize pertinent orders related to wound treatments, including pressure reduction surfaces,</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46403</p> <p>Based on observation, interview and record review, the facility failed to ensure each resident who needs respiratory care, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals, and preferences for 1 (Resident #1) of 1 resident reviewed for tracheostomy care.</p> <p>The facility failed to ensure Resident#1's oxygen concentrator was functioning properly on 03/20/25 and 03/21/25.</p> <p>This failure could place residents at risk of serious injury or hospitalization .</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 03/20/25, reflected a [AGE] year-old male, with an admitted [DATE]. Resident#1 had diagnoses of amputation of limbs as the cause of abnormal reaction of the patient, or of later complication, without misadventure at the time of the procedure and tobacco use.</p> <p>Record review of Resident #1s annual MDS Assessment , dated 03/10/25, reflected Resident #1</p> <p>had a BIMS score of 11, which meant Resident #1 had a moderate level of cognition. Resident was not coded for oxygen use.</p> <p>Record review of Resident# 1's Care plan, undated, reflected Resident#1 was at risk of shortness of breath and chest pains. Resident#1's goals reflected no complaints of shortness of breath and chest pain. Resident#1's interventions included apply oxygen as ordered and monitor for effectiveness.</p> <p>Record review of Resident#1 physician order dated,03/05/25 reflected Oxygen at 2L/min via Nasal Cannula, as needed Administrative oxygen 10 liters from non-rebreather mask as needed for Shortness of breath, cyanosis, respiratory distress, labored breathing. Tachypnea no improving with the use of O2 from nasal cannula and notify medical doctor.</p> <p>Observation and interview on 03/20/25 at 4:00 PM, revealed bo oxygen warning sign outside of Resident#1 door. Observed the oxygen concentrator in Resident#1's room was beeping continuously. At the top of the concentrator a solid red LED light above the wrench symbol was displayed. Beside the red light was a solid yellow LED light above the O2 symbol. Resident #1 stated his oxygen machine has been that way since, he had been in the facility. Resident#1 stated the oxygen machine used to keep him up at night with the beeping but now he had gotten used to it.</p> <p>Observation and interview on 03/20/25 at 4:15 PM, CMA E stated she would let the charge nurse know about the concentrator beeping. The CMA E stated this was the first time she has heard the machine beeping. CMA E stated the resident needed the machine to work properly for his shortness of breath.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview with the interim director of nursing on 03/21/25 at 5:00 PM revealed a new concentrator was in Resident#1's room. The interim director of nursing turned on the concentrator and the machine beeped several times and a yellow light showed above the O2 sign. The concentrator stopped beeping and the yellow light stayed on. The interim director stated the facility has several oxygen concentrators and will replace the concentrator in Resident#1 room. The interim director of nursing tried two more machines before finding a concentrator that worked correctly. The interim director of nursing stated nursing staff should check the concentrator to ensure it was functioning correctly at every shift. Interim director nursing stated the vendor would be notified to replace and service the oxygen concentrators.</p> <p>Interview on 03/21/25 at 5:15 PM Resident#1 stated he had to have his oxygen because he had trouble breathing.</p> <p>Interview on 03/21/25 at 5:35 PM, the primary care physician stated it was important for residents to have a functioning oxygen machine especially if the resident needs it. If the resident was not able to keep his saturation above 92 he needs to have the oxygen in place so, he can maintain his oxygen levels.</p> <p>Interview on 03/21/25 at 5:45PM, the Administrator and the interim director of nursing stated the nursing staff were responsible for checking the oxygen concentrator and ensure it was functioning properly. The interim director of nursing stated the nursing staff should check the hose and make sure the water is bubbling. Staff should notify the ADON and the number on the concentrator. The Interim director of nursing stated nursing manager stated</p> <p>Record review of the facility policy, Oxygen Concentrator, dated 10/23, reflected:</p> <p>4. Use of the Concentrator: The nurse shall verify .</p> <p>g. Plug the unit in and turn the unit on to the desired flow rate. Assess for proper functioning:</p> <p>i. If using a mask, feel for air flow.</p> <p>ii. If using a nasal cannula, pinch the tubing near the prongs to listen for a higher-pitched sound caused by the release of increased pressure.</p> <p>i. Place an oxygen warning sign on the resident's door.</p> <p>Record review of manufacture manual titled Drive DeVilbiss(R) 10-Liter Oxygen Concentrator Instruction Guide, dated Overview of alarms .This device contains an alarm system which monitors the state of the device and alerts of abnormal operation, loss of essential performance or failures. Alarm conditions are shown on the LED display. The alarm system functions are tested at power up by lighting all visual alarm indicators and sounding the audible alarm (beep) . O2 symbol means low Oxygen Concentration .yellow led light above O2 symbol means low O2 , when O2 is <86% Wrench symbol meant malfunction .red led light above the wrench symbol meant Service Required.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46403</p> <p>Based on observations, interviews, and record reviews the facility failed to 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 one (Resident #1) of five residents reviewed for infection control.</p> <p>On 03/20/25 and 03/21/25 CMA E, CNA F and HK G failed to put on PPE before entering Resident#1 room.</p> <p>This failure could place residents at risk of cross contamination of infections from other residents.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 03/20/25, reflected a [AGE] year-old male, with an admitted [DATE]. Resident#1 had diagnoses of amputation of limbs as the cause of abnormal reaction of the patient, or of later complication, without misadventure at the time of the procedure and tobacco use.</p> <p>Record review of Resident #1s annual MDS Assessment, dated 03/10/25, reflected Resident #1 had a BIMS score of 11, which meant Resident #1 had a moderate level of cognition.</p> <p>Record review of Resident# 1's Care plan, undated, reflected Resident#1 was at risk of shortness of breath and chest pains. Resident#1's goals reflected no complaints of shortness of breath and chest pain. Resident#1's interventions included apply oxygen as ordered and monitor for effectiveness.</p> <p>Record review of Resident#1 progress notes dated 03/20/25 reflected, called [lab] to inquire on C. Diff results. Results are still pending. Written by interim director of nursing.</p> <p>Record review of Resident#1 physician order, dated 03/21/25 reflected, Contact Isolation every shift for diarrhea more than 3 per day Place contact precautions sign up on door and on isolation caddie. Staff must wear gown and gloves.</p> <p>Observation on 03/20/25 at 10:00 AM, revealed signage outside the Resident#1 door revealed STOP Contact precautions everyone must: clean their hands, including before entering and when leaving the room. Providers and staff must also: Put on gloves before entry. Discard gloves before room entry. Put on gown before entry. Discard gown before exit. Do not wear the same gown and gloves for more then one person .</p> <p>Observation on 03/20/25 at 4:10 PM revealed the CNA F went into Resident#1's room with no PPE before entering Resident#1 room. CNA F stated she entered Resident#1's room because he was yelling that he was hungry and did not have lunch. CNA F talked with Resident#1 about his tray and exited the room. Observed CNA F walk down the hallway to the dining room area. CNA F continued down another hall to answer a call light.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview on 03/20/25 at 4:45 PM, MA E went into Resident#1's room with no PPE to bring him medication and returned to the hallway. MA E went to the dining hall to get Resident#1's dinner tray. MA E stated she did not have to put on PPE because she was not providing care to the resident. MA E stated PPE was worn to prevent spread of infection.</p> <p>Interview on 03/20/25 at 5:00 PM, LVN G stated Resident#1 was on isolation because there was a suspension of C. Diff</p> <p>Interview on 03/20/25 at 5:12 PM, the CNA F stated she had just made it back from vacation and did not notice the sign outside Resident#1's door. CNA F stated no one had told her that she needed to put on gowns and gloves before entering the resident's room. CNA F stated she was just trying to help and was not assigned to that hall.</p> <p>Interview on 03/21/25 at 9:10 AM the WCN I stated Resident#1 had been tested for C. Diff and results had not come back yet. WCN I stated when entering Resident#1 room staff and visitors needed to put on gown and gloves to prevent the spread. WCN I stated C. Diff was highly contagious</p> <p>Interview and observation on 03/21/25 at 2:30 PM, revealed the HK H went into Resident#1's room with no PPE to clean up while he was gone to dialysis. The HK H stated since the resident was not in the room she did not have to put on the PPE.</p> <p>Interview on 03/21/25 at 5:45PM, the Administrator and the interim director of nursing stated all staff were responsible for following infection control policies to prevent the spread of infection. C.diff was highly contagious and can spread quickly. The interim director of nursing stated the nursing managers will be responsible for training the nursing staff on infection control policy and procedures. The interim director of Nursing stated she had been in the facility for two weeks and the Administrator started three days ago and the DON would start approximately next week. The interim director of nursing was the infection preventionist and received her certificate on 09/11/24.</p> <p>Record review of facility policy undated Infection Prevention and control program reflected An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections.</p>		