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FOX RUN VILLAGE	41215 FOX RUN ROAD NOVI, MI 48377

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F0000 SS=	INITIAL COMMENTS Fox Run Village was surveyed for a Recertification survey on 3/13/25. Census:40	F0000		
F0658 SS= D	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure Nursing standards of practice were followed for medication administration for one resident (R5) of five residents reviewed for medication administration. Findings include: On 03/11/25 at approximately 10:52 a.m., R5 was observed in their room, laying in their bed. R5 was observed to have eye drops and a "medication cup" with three white pills in it without a Nurse in the room providing supervision. R5 was queried how they received their pills in the cup, and they reported the Nurse had given it to them to take and did not wait for them to take them all, left the room and never returned. At that time, R5 was observed to take their hand and grab the pills one by one out of the cup and swallow them.	F0658		

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

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.

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	On 3/12/25 at approximately 9:29 a.m., during a medication administration observation, Nurse "E" was observed to administer a Cyancobalamin (vitamin B-12) 1,000 mcg tablet in a medication cup with multiple other medications in together in the cup at the same time. A review of the pharmacy instructions for the administration of the Cyancobalamin revealed the Cyancobalamin was to be administered "sublingually" (under the tongue). Further review of the pharmacy instructions revealed the following: "dissolve under tongue only." On 03/12/25 at approximately 9:49 a.m., during a review of the medication administration observation with Nurse "E", Nurse "E" was queried why they administered the cyancobalamin with the rest of the medications in the medication cup to R5 instead of following the pharmacy instructions and administering it sublingually, and they indicated that they usually do administer it sublingual but had forgotten that morning. On 3/11/25 the medical record for R5 was reviewed revealed the following: R5 was last admitted to the facility on 10/4/22 and had diagnoses including Congestive heart failure and Polyneuropathy. A review of R5's MDS (minimum data set) with an ARD (Assessment reference date) of 1/3/25 revealed R5 needed assistance from facility staff with their activities of daily living.			

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	A Physician order revealed the following: Refresh Tears 0.5 % eye drops (2 drops) DROPS Both Eyes Notes: Indication: for dry eyes (Dispense as written) OK to SELF ADMINISTER/LEAVE AT BEDSIDE., Instructions:... Further review of the medical record did not reveal any other Physician orders for the self-administration of any other medications On 3/13/25 at approximately 9:00 a.m., during a conversation with the Assistant Director of Nursing, (ADON), the ADON was queried regarding both of the medication observations pertaining to R5's medication administration and they indicated that it was the responsibility of the Nursing staff to follow the rights of medication administration including clarifying the pharmacy instructions vs the orders and ensuring residents have successfully ingested all the medications that were administered by providing supervision during administration.			
F0677 SS= D	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F0677		

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	Based on observation, interview and record review, the facility failed to consistently provide assistance with oral hygiene for one (R34) of two residents reviewed for activities of daily living (ADLs). Findings include: On 3/11/25 at 10:18 AM, R34 was observed lying in bed. When asked if they had any concerns with the facility's care R34 reported they had concerns with staff not always assisting them with brushing their teeth most of the time. R34 reported oral care had not been done yet today. On 3/11/25 at 12:39 PM, R34's call light was lit up in the hallway and the door was closed. Upon entering the room, the resident was observed lying in bed on their back with a lunch meal on an overbed tray in front of them. When asked if they had pressed their light for help, R34 reported their bed controller fell to the floor and they couldn't reach it. The bed remote controller was observed on the floor under the bed. When asked if they had received any oral care yet, R34 reported not yet. The resident further reported they were used to doing that by themselves when they were in their apartment before coming here. R34 stated, "I'm dependent on them to do it when I can't get out of bed in my chair." They reported they required a mechanical lift with a sling and two people to get them out of bed.			

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	When asked if they were having any mouth/tooth pain, they stated no but also reported they had a dental appointment next week for a routine cleaning and that seemed to be when they got their teeth cleaned. They further reported they took pride in the fact they always took good care of their teeth and now was worried it wasn't being done like it should. On 3/11/25 at 12:43 PM, the Care Assistant (CA 'D') who was assigned to R34 entered the room to inquire about the activated call light. R34 reported the bed remote had fallen. At that time, CA 'D' was asked about what care had been provided to R34 earlier this morning. They reported they had only given them their meal trays. When asked if they had provided any oral care to R34 this morning, CA 'D' reported they had not. When asked about why not, such as if their assignment was too much, CA 'D' reported they were busy and had eight residents in their assignment. When asked if they had reported to the Nurse they were not able to complete any of the resident care needs, they reported they did not. Review of the clinical record revealed R34 was admitted into the facility on 9/19/24 with diagnoses that included: displaced bimalleolar fracture of right lower leg, other fracture of right lower leg, pleural effusion, and unspecified injury of head. According to the Minimum Data Set (MDS)			

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	assessment dated 12/20/24, R34 scored 7/15 on Brief Interview for Mental Status Exam (BIMS) which indicated severe cognitive impairment (however the resident was able to recall specific details during this survey that were correct) and required setup or clean-up assistance in which the helper sets up or cleans up and the resident completes the activity for oral hygiene. According to the resident's holistic care plans, R34 required one-person limited assistance with grooming, and had natural teeth. There was no specific care plan for the resident's oral hygiene status, however the care plan for assistance in bathroom identified they required total dependence of one-person physical assist. Review of the oral care documentation provided by the facility included documentation that staff were to provide documentation of the level of assistance required for all ADL (which covered section GG of the MDS assessment for all three shifts: 7:30 AM-3:30 PM; 3:30 PM-11:30 PM; and 11:30 PM-7:30 AM). The documentation provided revealed several shifts and dates from 3/1-3/12/25 that were left blank and others varied from R34 being dependent, requiring supervision, to being independent. There were no refusals of care documented. On 3/12/25 at 4:00 PM, an interview was conducted with the Assistant Director of Nursing (ADON). When informed of the			

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	observation and interview of R34 with CA 'D', the ADON reported oral care should be included as part of the morning care and CA 'D' had received routine training about that. The ADON further reported the staffing assignments were well within reason to be able to provide care and that should not have been an issue. When asked if they were aware if R34 had any behaviors of refusal of care, the ADON reported they were not aware of any refusal of care, but that from time to time the resident liked to stay in bed. On 3/13/25 at 9:00 AM, the facility was requested to provide any dental consultations since admission for R34. On 3/13/25 at 9:50 AM, the Administrator reported they didn't have any notes regarding dental, but reported R34 did have an appointment on 3/19/25 at 2:00 PM with the dentist on campus. Review of the documentation provided by the facility for Oral Care was an excerpt from the Lippencott Procedure which read, "...Oral care promotes patient comfort, nutritional intake, and oral health, and reduces dental plaque, oral colonization, and mucosal inflammation..." On 3/13/25 at 9:57 AM, an interview was conducted with the MDS Coordinator (Nurse 'F'). When asked about the ADL			

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	documentation provided for R34, Nurse 'F' reported that was how the facility documented oral care. They reported they had reviewed the same documentation provided to this surveyor and confirmed the blank entries, fluctuations in assistance required, and lack of any noted refusals.			
F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure medications were available for administration for one resident (R143) of one resident reviewed for new admissions. Findings include: On 03/11/25 at approximately 11:17 a.m., R143 was observed to be in their room, laying in their bed. R143 was observed to have a catheter draining amber colored urine into a drainage bag. On 3/12/25 the medical record for R143 was reviewed and revealed the following: R143 was initially admitted to the facility on	F0684		

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	3/10/25 and had diagnoses including Retention of Urine and Encounter for fitting and adjustment of urinary device. A review of R143's March 2025 Medication Administration Record (MAR) revealed R143 was not administered the following medications on 3/11/25 (a day after being admitted on 3/10/25): 1. doxycycline hyclate 100 mgcapsule (1) CAPSULE Oral Two Times Daily for Two Days Starting 03/10/2025... (10:00 AM dose-"med on order")...2. midodrine 5 mg tablet (1tab) (TABLET) Oral Three Times Daily Starting 03/11/2025...(9:00 AM dose-"Med on order" and 1:00 PM dose-"med on order")...3. famotidine 20 mg tablet (1) TABLET Oral One Time Daily Starting 03/11/2025...(9:00 AM dose-"on order")...4. ascorbic acid (vitamin C) 500 mg tablet (2) TABLET Oral Two Times Daily Starting 03/11/2025...(9:00 AM dose-"on order")... 5. Banatrol Plus oral powder packet (1 packet) POWDERIN PACKET (EA) Oral Three Times Daily Starting 03/11/2025...(9:00 AM dose-"on order" and 1:00 PM dose-"on order")...6. ferrous sulfate 324 mg (65 mg iron) tablet, delayed release (1 tab) TABLET,DELAYED RELEASE (ENTERICCOATED) Oral One Time Daily Starting 03/11/2025... (9:00 AM dose-"on order")...7. alphaÂ lipoicÂ acidÂ 600Â mgÂ tablet (1 tab) TABLET Oral One Time Daily Starting 03/11/2025...(9:00 AM dose-"med on order")..."			

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	On 3/13/25 at approximately 9:00 a.m., during a conversation with the Assistant Director of Nursing (ADON), the ADON was queried regarding the process for ensuring medications were available for administration the following shift for newly admitted residents. The ADON reported that the admitting Nurse ensures the medication orders are entered into the EMR (electronic medical record) and reconciles the medications with the medical provider during their admission assessment. The ADON was queried regarding R143 not having their medications available the day after their admission and the ADON indicated that the admitting Nurse should have implemented a STAT (ASAP) delivery to be made from the pharmacy as a drop ship which arrives in 2-4 hours or the Nurse should have checked the backup box to ensure the medications were administered timely and according to Physician orders. At that time the ADON indicated they would have to look into the issue. No further information was provided before the end of the survey as to why R143 did not have their medications available the following day for administration.			
F0690 SS= D	Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition	F0690		

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	is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure Physician orders were in place and appropriate catheter care was provided for one resident (R143) of two residents reviewed for indwelling catheters. Findings include: On 03/11/25 at approximately 11:17 a.m., R143 was observed to be in their room, laying in their bed. R143 was observed to			

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	have a catheter tube draining amber colored urine into a drainage bag. On 3/12/24 at approximately 2:44 p.m., R143 was observed in their room, walking around in their hospital gown, dragging their catheter tubing and urine collection bag on the floor without any privacy bag in it. R143's catheter tubing was not observed to be secured and was observed to be pulling away from their body as they were walking. On 3/12/25 the medical record for R143 was reviewed and revealed the following: R143 was initially admitted to the facility on 3/10/25 and had diagnoses including Retention of Urine and Encounter for fitting and adjustment of urinary device. A review of R143's "holistic assessment 7.0" revealed the following: "Continence-Urine Retention...I use a(n): suprapubic catheter...Catheter size 18Fr...Diagnosis Urine Retention....Urine: Amber..." A review of R143's Physician orders did not reveal any active Physician orders for the instruction/care or monitoring of R143's Suprapubic catheter On 3/12/25 at approximately 2:41 p.m., the medical record for R143 was reviewed with Nurse "E". Nurse "E" was queired if R143 had any Physician orders addressing the care and monitoring of their catheter. Nurse "E" was observed reviewing the record and reported			

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	that R143 did not have any orders for the care of their catheter and that the Nurse who admitted them should have place them in the record. At that time, Nurse "E" reported that they would have to put in the orders for R143's catheter care including orders for their dressing change every day and general catheter care per shift. On 03/13/25 at approximately 9:00 a.m., during a conversation with the Assistant Director of Nursing (ADON), the ADON was queired regarding the admitting physician orders for R143's catheter care. The ADON indicated that the orders for catheter care should be entered by the admitting nurse when the initial evaluation is completed, so that documentation of the care can be done. The ADON indicated they would review the concern and return if they had any further information. No further information regarding the lack of Physician orders for R143's catheter was provided by the end of the survey.			
F0880 SS= E	Infection Prevention & Control §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a	F0880		

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	minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will			

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	conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure appropriate infection control practices for residents on droplet precautions during an influenza outbreak, and implementation of Enhanced Barrier Precautions (EBP) affecting multiple residents reviewed for infection control, including R93, R21 and R15. This deficient practice has the likelihood to result in cross-contamination and the continued development and spread of infection and disease. Findings include: R93 On 3/11/25 at 10:09 AM, R93's door was closed and the resident was heard coughing very loudly from the hallway. There were several signs taped to the outside of the door which included: a rehab treatment schedule, a sheet that read, "STOP PLEASE SEE NURSE", a sheet that showed the sequence of putting on personal protective equipment (PPE) for a gown, mask or respirator, goggles or face shield, and gloves, and a sheet that showed the sequence of removing PPE. There was no signage to identify what type of precautions the resident was on, or what			

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	specific PPE to use. There was no Nurse or Care Assistant (CA) observed in the hallway for approximately 10 minutes. On 3/11/25 at 10:19 AM, CA 'D' was observed exiting R93's room wearing only a black KN95 mask (no gown, face shield/goggles, or gloves). CA 'D' was not observed to wash their hands, or use hand sanitizer, and proceeded to exit the room into the hallway. On 3/11/25 at 10:20 AM, an interview was conducted with CA 'D'. When asked about why R93 was on isolation precautions, CA 'D' pointed to the signs on the door, confirmed there was nothing specific posted and stated they thought it was for the flu. When asked what PPE was required to be worn, CA 'D' reported a gown and a N95 mask. When asked why they had not donned PPE when they were in R93's room, CA 'D' reported they just went into the room to give the resident their meal tray and acknowledged the meal was delivered later than usual. When asked if again what PPE should be worn upon entering the room, CA 'D' stated when they touched the resident or do something in the room they put on N95 mask, gloves, and gown. CA 'D' confirmed there were no N95 masks available in the PPE cart outside the room. CA 'D' then went to go find the Nurse to inquire about the N95 masks. On 3/11/25 at 10:27 AM, Nurse 'E' was			

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	observed in the hallway coming from the central dining area. When asked about the specific isolation precautions for R93, Nurse 'E' reported the resident was on droplet precautions. When asked what PPE should be donned prior to entering the room, Nurse 'E' reported anyone entering the room should be wearing an N95 mask. When informed there were no masks available on the PPE cart outside the room, Nurse 'E' reported the N95 masks were kept in the nursing station. When asked how visitors would know to go there to obtain those, or what specific PPE needed to be donned/doffed, Nurse 'E' reported that was a good question and most visitors usually approached them. When informed that they were not observed as available for approximately 10 minutes, Nurse 'E' acknowledged they were doing medication administration at this time. When asked if the PPE carts should have all required PPE available, they reported they should. On 3/11/25 at 10:45 AM, CA 'D' was observed outside of R93's room wearing a disposable gown, the same black KN95 mask as observed earlier, as well as a N95 mask over the KN95 mask. When asked about the donning of both masks, they reported that was ok, so they could continue to use the KN95 mask. They were requested to follow-up with nursing administration regarding that practice. CA 'D' then removed the black KN95 mask and put it into their pocket.			

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	On 3/11/25 at 10:48 AM, upon CA 'D' entering R93's room, Nurse 'E' was observed exiting the resident's room with the entire nursing pushcart that contained several items including: disposable straws, spoons, cups, a laptop, a sharps container, and an opened container of yogurt. Nurse 'E' was not observed to use hand sanitizer upon exiting the room, nor sanitizing any of the items on the push cart. Nurse 'E' then immediately proceeded to go into R21's room (which was not currently on any precautions as there was no signage or PPE cart at/near the resident's room but should have been on enhanced barrier precautions for an open wound per physician orders as of 2/27/25). Nurse 'E' was overhead asking the resident if they were ready for their medications. Review of the clinical record revealed R93 was admitted into the facility on 3/7/25 with diagnoses that included influenza A. There was no Minimum Data Set (MDS) assessment completed at this time. According to the physician's orders in the hard chart, R93 was on droplet precautions for influenza A since admission on 3/7/25. Review of the care plans revealed there were none for resident's diagnosis of influenza A or what specific isolation precautions to follow. R21			

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	On 3/11/25, multiple observations were made of R21's room. There were no signs posted identifying R21 was on any precautions, or PPE carts made available until the morning of 3/12/25. On 3/12/25 at approximately 9:30 AM, R21's room now had signage that indicated they were on enhanced barrier precautions (EBP) and a PPE cart was in the hallway outside of their room. Review of the clinical record revealed R21 was admitted into the facility on 4/14/23 with diagnoses that included: chronic systolic heart failure, dementia without behavioral disturbance, chronic kidney disease, sarcoidosis, chronic obstructive pulmonary disease, and Alzheimer's disease. According to the MDS assessment dated 1/17/25, R21 had severe cognitive impairment (scored 5/15 on BIMS) and no skin/wound concerns. Review of the physician orders revealed no orders included in the hard chart identified R21 had wound care orders to the left heel which started on 2/29/25. Additionally, R21 had orders for enhanced barrier precautions due to a wound on 2/27/25, but this was not observed as implemented during the survey until 3/12/25. Further review of the progress notes revealed R21 was on droplet precautions for +influenza A starting on 3/4/25, tested			

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	positive on 3/7/25 and was removed off droplet isolation on 3/11/25. It should be noted there were no isolation precautions observed in use via either signage or PPE cart on 3/11/25. R15 On 3/11/25 at 10:52 AM, the resident was observed working with therapy staff in their room. There was no EBP signage posted, or PPE cart available and/or in place at that time. On 3/12/25 at 8:15 AM, R15's room was now identified as the resident being on EBP. Observation of the PPE cart revealed there were only disposable yellow gowns available. There were no gloves or hand sanitizer available for use. Review of the clinical record revealed R15 was admitted into the facility on 1/27/25 with diagnoses that included: hypo-osmolality and hyponatremia, influenza due to other identified influenza virus with other respiratory manifestations (onset date 2/26/25), presence of right artificial knee joint, aftercare following joint replacement surgery, and acute posthemorrhagic anemia. According to the MDS assessment dated 2/3/25, R15 had intact cognition. Review of the physician orders revealed orders for EBP were not written until 3/12/25.			

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	Review of the progress notes revealed changes to the resident's right knee on 3/10/25 which included: An entry on 3/10/25 at 4:25 PM by Nurse 'I' read, "Blister filled with pus to right knee noted 1x1cm (centimeter), open, not warm to touch and it is not affected per [Physician 'K']. The wound cleansed with NS (Normal Saline). TAO (Treatment As Ordered) applied and covered with Opti foam daily until healed. After treatment the blister open and purulent discharge noted..." An entry on 3/10/25 at 1:16 PM by Nurse 'I' read, "...the wound to right knee, open, has purulent drainage, not warm to touch and it is not affected <sic> per [Physician 'K']. Ordered placed to change the dressing daily..." Additional review of the care plans revealed there were none implemented to address the resident's use of EBP or droplet precautions for when they were identified as positive for influenza A on 2/26/25. On 3/12/25 at 3:47 PM, an interview was conducted with the infection Preventionist who also performed duties as the Assistant Director of Nursing (ADON). They reported they just took over the infection control program about a month ago. At that time, the ADON was informed of the concerns regarding the facility's infection control practices as observed, including interviews			

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	with staff. The ADON reported the staff had recently received multiple education and training including what to don/doff, how to ensure supplies were available, and the specific requirements including what and how to don/doff for residents on droplet precautions and EBP. When asked if staff should be bringing the nursing pushcart into rooms that were on droplet precautions, the ADON reported the WOW (Workstation on Wheels) should be disinfected upon leaving an isolation room. They further reported the observations and interviews with staff were not reflected of their training. When asked if the facility's decision to not post specific signage of the type of precaution and what specifically to don and doff, how were staff and/or visitors to know exactly what to do, the ADON reported they should see the nurse or also should be on the care plan. When asked how staff and/or visitors would access the care plans given those were kept in binders inside the rooms and would have to enter those rooms, without following appropriate infection control practices, the ADON reported that was a good question and was not able to offer any further explanation. On 3/13/25 at 10:40 AM, an interview was conducted with the Director of Nursing			

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	(DON). At that time, the same concerns were reviewed as with the ADON. The DON confirmed the reported observations and interviews were not in accordance with appropriate infection control practices and also was not what staff were educated to do. In regard to Nurse 'E' bringing the WOW into a droplet precaution room, the DON reported there is no reason that should have been brought into the room. Review of the documentation provided for the specific isolation precautions included: A facility document titled, "Continuing Care Isolation Precautions Resource Tool" which included: "...Enhanced Barrier Precautions...PPE Requirements...Gloves and gown prior to the high-contact care activity...PPE to be changed before caring for another resident...Make PPE, including gowns and gloves available and accessible to staff before performing high contact activities...Ensure access to alcohol-based hand rub is available... ...Droplet Precautions All residents infected with a disease which spreads through droplets during coughing, sneezing or talking. Examples include Influenza...When PPE Used...Any Room Entry...PPE Requirements...Gloves, Gown, Mask (Surgical or N95 Masks), Protective eyewear, (Don prior to room entry, doff prior to room exit)...PPE to be changed before caring for			

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	another resident...Isolation Cart at entryway...Appropriate Signage in place..." On 3/11/25 there were three rooms that were noted to have a posting stating "STOP SEE NURSE". There was instruction for how to don and doff personal protective equipment (PPE), but no information on what PPE to put on. On 3/13/25 at 10:00 AM, an infection control meeting was conducted with the Assistant Director Of Nursing (ADON) / Infection control preventionist (ICP). They were asked about the rooms that had the signage "STOP SEE NURSE" and asked how visitors and staff members would know what PPE to wear or what's required if the type of isolation nor the instructions for what to wear is not available on the posting. The ADON explained that individuals are supposed to see the nurse and they should be able to tell individuals what is required. The ADON was then asked what if a nurse is not present, how would one know what to do or what isolation is present. The ADON replied, that it was being discussed with corporate, because this facility is very big on homelike environment and making sure the residents are dignified, but understood the safety in having the correct information present so employees and visitors could properly protect themselves. No additional information was provided by the exit of survey.			

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