STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(x2) multiple construction	(X3) DATE SURVEY COMPLETED
	365209	a. building _____ b. wing _____	06/05/2025

name of provider or supplier	street address, city, state, zip code
MAJESTIC CARE OF MIDDLETOWN LLC	6898 HAMILTON MIDDLETOWN ROAD MIDDLETOWN OH, 45044

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000	INITIAL COMMENTS ANNUAL SURVEY COMPLAINT INVESTIGATION MASTER COMPLAINT NUMBER OH00166357 INCLUDING COMPLAINT NUMBERS OH00165104, OH00164818 AND OH00163678 ADMINISTRATOR: Elisha Witcher, #7391 CERTIFIED BED CAPACITY: 200 CENSUS IN HOUSE: 148 The following deficiencies are based on the annual survey and complaint investigation completed 06/05/25.	F 0000		

laboratory director's or provider/supplier representative's signature | title | (x6) date

ELISHA.WITCHER | 07/07/2025

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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F 0584	Continued From page 1	F 0584		
F 0584 SS=D	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 0584	Tag Number: F584 Deficiency: The facility failed to provide a homelike environment by having ceiling tiles that had brown stains on them. Residents #54, #81 and #116 were affected by this deficient practice, with no negative outcomes. Ceiling tiles for the affected residents were changed by maintenance staff on 6/6/2025. A facility wide audit was conducted to identify any ceiling tiles with stains on them on 6/21/25 thru 6/23/25 and replaced by the Maintenance staff. ED/designee provided education to Maintenance supervisor and staff on ceiling tile and cluttered room on 6/9/25. Weekly rounds by the Maintenance supervisor/ designee to ensure that ceiling tiles are in good condition for 4 weeks, and then 2 times monthly for 2 months. Results will be reviewed by the QAPI Committee and used to guide continuous improvement. Date of Compliance July 1 0th	07/10/2025

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F 0584	Continued From page 2 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe, functional, and homelike environment for the residents. This affected three (Residents #54, #81 and #116) of the three residents reviewed for a homelike environment. The facility census was 148. Findings include: Observation of the resident rooms on 06/04/25 from 1:10 P.M. to 1:22 P.M. with Maintenance Director #510 revealed the following: a) Resident #54's room had a damaged, brown and black discolored ceiling tile above the resident's bed. b) Resident #81's room had three damaged, brown and black discolored ceiling tiles above the resident's bed, one broken ceiling tile with a portion of the ceiling tile missing, and one entire ceiling tile, approximately three feet by four feet that was missing.	F 0584		

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F 0584	Continued From page 3 c) Resident #116's room had three damaged, brown and black discolored ceiling tiles above the resident's bed. Interview on 06/04/25 at 1:22 P.M. with Maintenance Director #510, verified Residents #54, #81 and #116's room conditions.	F 0584		
F 0677 SS=D	483.24(a)(2) 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 STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to nail care for residents. This affected two (Residents #32 and #100) of three residents reviewed for care and services. The facility census was 148. Findings include: 1. Review of the medical record revealed Resident #32 was admitted to the facility on 11/19/20 with diagnoses of Alzheimer's dementia, Parkinson's disease, diabetes mellitus type II, bipolar disorder and psychotic disorder. Review of the Minimum Data Set (MDS) significant change assessment dated 04/02/25 revealed Resident #32 had	F 0677	Facility Name: Majestic Care of Middletown F0677 ADL Care for Dependent Residents State: Ohio Residents #32 and #100 identified during the survey were immediately assessed by the DNS/designee on 6/2/2025 reveal no negative outcomes related to the cited deficient practice. Both residents immediately received nail care by DNS/designee A facility-wide audit was conducted by DNS/designee on 6/18/2025- 6/20/2025 to identify residents who need ADL/nail care to ensure nails are clean and trimmed to the resident's preference. Residents care planned based on their personal preferences. Any discrepancies were corrected immediately by DNS/Designee, and appropriate interventions were implemented. All nursing/CNA staff received in-service training on ADL care per policy requirements, with emphasis on nail care DON educated staff on 6/18/2025. The DNS/designee will audit 5 random residents weekly for 4 weeks, then once weekly for 2 months. All findings will be reported to the QA committee for review, the committee meets monthly and as needed 5. Completion Date Date of compliance July 10, 2025	07/10/2025

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F 0677	Continued From page 4 significant cognitive impairment and was always incontinent of bowel and bladder. The resident required set up assistance with eating, oral and personal hygiene, maximal assistance with bed mobility and was dependent for toileting, bathing, dressing and transfers. During an observation on 06/02/25 at 4:33 P.M., Resident #32 was sitting in her wheelchair at the overbed table dressed in clean and seasonal appropriate personal clothing. All the resident's fingernails were long and jagged with an unknown material under the nails. Interview with the resident was attempted, but not possible due to the resident's cognitive impairment. 2. Review of the medical record revealed Resident #100 was admitted to the facility on 02/10/25 with diagnoses of diabetes mellitus type II, rhabdomyolysis, rib fracture (one), metabolic encephalopathy and alcohol dependence. Review of the Minimum Data Set (MDS) Medicare five-day assessment dated 02/16/25 revealed Resident #100 had moderate cognitive impairment and was always continent of bowel and occasionally incontinent of bladder. The resident required set up assistance with eating, supervision with oral hygiene and bed mobility and moderate assistance with toileting, bathing, dressing and transfers.	F 0677		

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F 0677	Continued From page 5 During an observation on 06/02/25 at 5:25 P.M., Resident #100 revealed resident sitting in his wheelchair at the overbed table eating supper and watching television, dressed in clean and seasonal appropriate personal clothing. All the resident's fingernails were long and jagged with an unknown material under the nails. During an interview at the time of the observation, Resident #100 stated he would like nail care to be completed by the nursing staff. During an observation and subsequent interview on 06/03/25 at 1:22 P.M., the Director of Nursing (DON) verified the fingernails of Residents #32 and #100 were long, jagged, dirty and in need of care.	F 0677		

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F 0756	Continued From page 6	F 0756		
F 0756 SS=D	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop	F 0756	F0756 – Drug Regimen Review The resident #135 during the survey had their medication regimen reviewed by the Nurse Practitioner on 6/4/24 in house who addressed the recommendation. PRN order implemented on 6/4/2024. A retrospective audit of all residents' monthly drug regimen reviews over the past 60 days was conducted 6/25/25 by the consultant pharmacist. Any missed or undocumented irregularities were addressed, and physicians were notified to ensure appropriate follow-up and documentation 7/2/25. Nursing leadership will be educated by RNC on ensuring timely follow- up to pharmacy recommendations by Date 6/18/2025. The DON or designee will audit 100% of pharmacist recommendations weekly x 4 weeks then monthly x 2 months. All findings will be reported to the QA committee for review, the committee meets monthly and as needed Compliance date July 10, 2025	07/10/2025

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F 0756	Continued From page 7 and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to followed ordered pharmacy recommendations. This affected one (Resident #135) of five residents review for unnecessary medications. The census was 148. Findings include: Review of Resident #135's medical record revealed an admission date of 11/15/24. Diagnoses listed included tremors, anemia, depression, chronic pain syndrome, thrombocytopenia, anxiety, tracheostomy, and type two diabetes mellitus. Review of a pharmacy recommendation dated 04/08/25 revealed a recommendation was made for as needed (PRN) Narcan (narcotic reversal medication) to be on hand due to Resident #135 having current orders for an opioid (Oxycodone) along with a benzodiazepine (Clonazepam). This combination increases the risk of life-threatening overdose. The pharmacy recommendation was documented as	F 0756		

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F 0756	Continued From page 8 accepted with a verbal order from physician. Review of physician orders revealed Narcan PRN was not ordered for Resident #135 until 06/04/25. During an interview on 06/05/28 at 8:18 A.M. the Director of Nursing (DON) confirmed PRN Narcan was not ordered until 06/04/25. The DON confirmed PRN Narcan was not ordered timely and was not ordered until Resident #135's pharmacy recommendations were requested.	F 0756		

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F 0761	Continued From page 9	F 0761		
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This STANDARD is not met as evidenced by: Based on observation, record review, staff interviews, and policy review, the facility failed to ensure insulin vials were properly labeled and stored. This affected three	F 0761	Plan of Correction for F0761 – Label/Store Drugs and Biologicals During the observation of the Aspen Med Cart it was found that resident's #23, #29 , and#128 insulin pen injector was not dated when removed from the refrigerator and placed in the cart. Correction made by the staff member at the time of observation. A full house audit of all medication carts was conducted by DNS/designee on 6/4/2025 . Any expired, improperly labeled, or unsecured medications were discarded or corrected. Staff were educated by DNS/designee on 6/4/2025 on the facility medication storage policy to reinforce labeling standards, including expiration dates, and the proper way to store insulin and date. The DNS/designee will conduct weekly audits weekly on medication carts for 4 weeks, then 2 times a month for 2 months. All findings will be reviewed by the QAA committee, the committee meets monthly and as needed. Compliance date of July 10, 2025	07/10/2025

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F 0761	Continued From page 10 (Residents #23, #29 and #128) of the 26 residents with medications stored in the Aspen medication cart. The facility census was 148. Findings include: During an observation of the Aspen medication cart on 06/04/25 at 8:48 A.M., Licensed Practical Nurse (LPN) #521 found Resident #23's Lantus insulin pen-injector was not dated when removed from the refrigerator and placed in the medication cart for administration; Resident #29's Glargine insulin pen-injector was not dated when removed from the refrigerator and placed in the medication cart for administration; and Resident #128's Tresiba pen-injector was not dated when removed from the refrigerator and placed in the medication cart for administration. During an interview at the time of the observation, LPN #521 verified none of the pens were dated when removed from stock. During an interview on 06/04/25 at 9:04 A.M, the Director of Nursing verified insulin vials and insulin pen-injectors are to be dated when removed from the refrigerator and placed in the medication cart for administration. During an interview on 06/05/25 at 2:43 P.M., Consulting Pharmacist #900 verified insulin vials/pen-injectors are to be dated when removed from refrigerated storage and placed in the medication cart for use.	F 0761		

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F 0761	Continued From page 11 Review of the policy titled, "Storage of Medications," revised August 2020, revealed certain medications or package types, such as intravenous (IV) solutions, multiple dose injectable vials, ophthalmics, nitroglycerin tablets, and blood sugar testing solutions and strips require an expiration date shorter than the manufacturer's expiration date once opened to ensure medication purity and potency.	F 0761		

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F 0812	Continued From page 12	F 0812		
F 0812 SS=F	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This STANDARD is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to ensure food storage areas were clean and food items were store appropriately. This had the potential to affect all residents that eat food from the kitchen. The facility identified eight (Residents #57, #89, #92, #101, #108, #122, #134, and #139) residents that did not eat food from the kitchen. The facility also failed to ensure	F 0812	Facility Name: Majestic Care of Middletown Survey Date:06/02/2025 Plan of Correction Tag: F0812- Failure to store, prepare, distribute, and serve food under sanitary conditions. All residents potentially affected by the deficient practice were assessed DNS/designees on 06/06/2025. No residents exhibited signs or symptoms of foodborne illness. The affected food storage and preparation area were immediately cleaned and sanitized by the Regional Dietary Manger on 06/03/2025. All improperly stored food items were discarded. A facility-wide audit of all food storage, preparation, and service areas was conducted by ED on 06/03/2025. No additional concerns were identified. Staff were interviewed and observed to ensure compliance with sanitary food handling practices. All dietary staff were educated on proper food handling, storage, and sanitation procedures per CMS and Ohio Department of Health guidelines by the Executive Director on 06/06/2025. The DON or designee will audit the resident refrigerators weekly to ensure that they are clean and there is no expired food. The dietary manager, Executive Director/designee will conduct random weekly audits of food storage and preparation areas. The Dietary Manager or Executive Director will complete weekly sanitation audits for 4 weeks. Results will be reviewed during the facility's Quality Assurance, and Performance Improvement (QAPI) meetings The DON or Designee will audit the resident refrigerators to ensure that they're clean, and no expired food 3 times a week x 4 weeks Any identified issues will be addressed immediately with retaining and corrective action. The facility	07/10/2025

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F 0812	Continued From page 13 resident refrigerators were clean. This affected Resident #36. The census was 148. Findings include: 1. During an observation on 06/02/25 at 9:03 A.M., the refrigerator in the kitchen had food storage shelves were dirty and covered in debris. The shelves had spots of a blackish green substance. Several milk cartons were in a plastic tub in the refrigerator. The milk cartons were sitting in water. No ice was in the tub. 2. During an observation 06/02/25 at 9:08 A.M., the dry storage area in the kitchen had a large plastic container containing dry cereal that was on a roll cart. The container did not have a lid. A rubber floor mat was near the cart was above the level of the cereal. The room as dirty and the floor was covered in debris. Several plastic bowls containing dry cereal were on the cart. The bowls were not labeled or dated. During an interview on 06/02/25 at 9:11 A.M., Dietary Manager (DM) #610 confirmed the above observations. 3. During an observation on 06/02/25 at 10:30 A.M., Resident #36's refrigerator had spilled cranberry juice in the bottom of the refrigerator with multiple dead, black bugs in the spilled juice. During an interview at the time of the observation, Certified Nursing Assistant	F 0812	alleges compliance date July 10, 2025	

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F 0812	Continued From page 14 (CNA) #513 verified the above observation. spilled cranberry juice and dead bugs in the refrigerator in the room of Resident #36. Review of the facility policy titled, "Food Storage: Dry Goods", dated 2023, revealed storage areas will be neat, arranged for easy identification, and date marked as appropriate. Review of the facility policy titled, "Food Storage: Cold Foods", revised February 2023, revealed all foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. Review of the facility policy titled, "Environment", revised September 2017, revealed all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. All food contact surfaces will be cleaned and sanitized after each use.	F 0812		

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F 0880	Continued From page 15	F 0880		
F 0880 SS=F	483.80(a)(1)(2)(4)(e)(f) 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 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	F 0880	F0880: Water Management Program Facility Name: Majestic Care of Middletown Survey Date: June 5, 2025 Tag Number: F0880 Deficiency: The facility failed to implement a Legionella prevention plan, designate responsible personnel, or document control measures. The facility completed a review of all water management plan engineering protocols, which were all in place as of 6/20/25 by the maintenance director. The infection control prevention completed a review of all current residents with no findings related to the cited practice 6/6/25. As a precaution, the ED and Maintenance Director conducted an immediate risk assessment and flushed all water outlets to reduce potential exposure. All members of the WMP will complete CDC Legionella Training by July 10 A Water Management Team has been established, including the Administrator, Maintenance Director, Infection Preventionist, and Environmental Services. The facility has developed and adopted a comprehensive Water Management Program (WMP) in accordance with CDC Toolkit and ASHRAE Standard 188. The WMP includes: A detailed building water system diagram Hazard analysis identifying areas at risk for Legionella growth Control measures such as temperature monitoring, flushing protocols, and disinfectant levels Monitoring procedures and corrective actions for deviations Documentation and communication protocols The WMP will be reviewed quarterly by the Water Management Team. Monthly logs will be maintained for all control measures by Maintenance Director The facility will conduct annual validation of the WMP, and Legionella	07/10/2025

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F 0880	Continued From page 16 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 conduct an annual review of its IPCP and update their program, as necessary.	F 0880	testing if indicated. Findings will be reported to the QAPI Committee for oversight. Date of Compliance July 10, 2025	

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F 0880	Continued From page 17 This STANDARD is not met as evidenced by: Based on record review, observation, interview and policy review, the facility failed to have a Legionella prevention program. This had the potential to affect all residents of the facility. The facility also failed to to ensure staff changed gloves and washed their hands appropriately during incontinence care. This affected one (Resident #97) of three residents reviewed for incontinence. The census was 148. Findings include: 1. Review of the facility's water management documentation revealed no evidence of an implemented Legionella prevention plan. There was no documentation of any members designated to manage a Legionella prevention plan. There was no documentation of any control measures being put in place to prevent Legionella. During an interview on 06/04/25 at 3:35 P.M., Maintenance Supervisor (MS) #496 and the Administrator stated there was not an implemented Legionella prevention plan. MS #496 confirmed there was no documentation of any control measures in place to prevent Legionella. Review of the facility's policy titled "Water Management Program", dated 05/15/25, revealed the water management program (WMP) is-a multi-faceted process	F 0880		

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F 0880	Continued From page 18 designed to reduce the growth and spread of opportunistic bacteria. The WMP includes developing a team, describing building water systems, identifying areas or devices where opportunistic bacteria such as Legionella might grow or spread to people, control measures, and remediation interventions when control measures are not met. 2. Review of the medical record revealed Resident #19 was admitted to the facility on 10/09/20 with diagnoses of intracerebral hemorrhage, hemiplegia and hemiparesis, morbid (severe) obesity, encephalopathy and depression. Review of the Minimum Data Set (MDS) quarterly assessment dated 11/22/24 revealed Resident #19 had no cognitive impairment, range of motion impairments on one side, upper and lower extremities and was always incontinent of bowel and bladder. The resident required set up assistance for eating, dependent for dressing and maximal assistance for oral and personal hygiene, toileting, bathing, bed mobility and transfers. Review of physician orders for Resident #97 revealed an order dated 01/01/25 to cleanse the suprapubic catheter site with soap and water and apply a drain sponge every shift. During an observation on 06/03/25 at 4:25 P.M., Resident #97, who was under	F 0880		

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F 0880	Continued From page 19 Enhanced Barrier Precautions (EBP), received catheter care and incontinence care in bed from Certified Nursing Assistant (CNA) #541. The resident was provided with catheter care and then bowel incontinence care. After catheter care and bowel incontinence care was provided, CNA #541, still wearing the gloves to provide catheter and incontinence care, touched the bathroom doorknob, bathroom sink faucet, applied a clean brief, pulled the resident's pajama bottoms up, and touched the wheelchair handles to move the wheelchair to the resident's bedside. CNA #541 doffed the gown and dirty gloves and left the room without washing and/or sanitizing her hands. Review of the EBP signage posted near the door to the room of Resident #97 revealed everyone must clean their hands, including before entering and when leaving the room. During an interview on 01/22/25 at 2:55 P.M., CNA #541 verified she did not change her gloves after completing incontinence care and before she touched the bathroom doorknob, bathroom sink faucet handle, application of clean brief on resident, pulling the resident's pajama bottoms up and touching the resident's wheelchair handles. She also verified she did not sanitize and/or wash her hands before leaving the resident's room. Review of the policy titled, "Enhanced	F 0880		

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F 0880	Continued From page 20 Barrier Precautions," dated 03/20/24, revealed it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Review of the policy titled, "Handwashing-Hand Hygiene," revised 03/05/25, revealed the purpose of the policy and procedure was to prevent the spread of infections through proper hand hygiene. Care team members must wash their hands for twenty (20) seconds using antimicrobial or non-microbial soap and water or use of an alcohol-based hand rub before and after direct contact with residents and after removing gloves. This deficiency represents non-compliance investigated under Complaint Number OH00164818.	F 0880		