STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175543	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING VIA CHRISTI VILLAGE MCLEAN	777 N MCLEAN BLVD , WICHITA, Kansas, 67203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F0000	INITIAL COMMENTS The following citations are the result of a Health Recertification Survey and complaint investigation 2566030.	F0000		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.	F0578		

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 reverse for further 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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F0578 SS = D	Continued from page 1 (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 32 residents, with 12 residents sampled for advanced directives (a written document, which indicates the medical decisions for health care professionals when the person could not make their own decisions). Based on observation, interview and record review, the facility failed to ensure one resident's advanced directives were thoroughly completed when Resident (R)34 had a do not resuscitate (DNR- or no code, a legal document or order that means the person does not desire resuscitative measures) which was only signed by two licensed nurses as a verbal order and lacked a physician signature rendering it invalid. This placed the resident at risk for an impaired right to have advance directives honored. Findings included: - R34 's Electronic Health Record (EHR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R34's "Annual Minimum Data Set" (MDS), dated 11/05/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS recorded no behaviors. R34 was totally dependent with activities of daily living (ADL) including bathing, toileting, dressing, footwear, transfers, and personal hygiene. The MDS recorded R34 required maximal assistance with oral care and moderate with assistance with eating. The MDS recorded R34 received an antianxiety (a class of medications that calm and relax people), and an antidepressant (class of medications used to treat mood disorders) on a routine basis. R34's “Psychotropic Drug Use Care Area Assessment” (CAA) documented R34 had significant behaviors and	F0578		

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F0578 SS = D	Continued from page 2 remained on multiple medications to help manage. Staff would continue to monitor for behaviors and undesired effects related to her medication. She was on hospice services and was anticipated to have a decline in all care areas. R34's "Quarterly Minimum Data Set," dated 05/06/25, documented the resident had a BIMS score of zero, which indicated severely impaired cognition. R34 was totally dependent with all ADLs. The MDS recorded R34 received antianxiety and antidepressant on a routine basis, and no behaviors. R34's "Care Plan" 10/16/24 documented R34 would have advance directives reviewed upon admission and at least annually. R34's "Physician's Orders" documented a DNR order, date ordered 10/16/24. R34's EHR, under the scanned document section, revealed a DNR, signed 09/15/22 by two nurses, that lacked a physician or provider signature. During an observation on 08/13/25 at 08:50 AM, R34 was sitting in her high-back wheelchair, and she had her right-hand splint on. During an interview on 08/13/25 at 10:00 AM, Licensed Nurse (LN) G reported that the Social Service Designee (SSD) X was responsible for obtaining the advanced directives for the residents. LN G reported that all DNRs required a physician's signature. During an interview on 08/13/25 at 04:00 PM, SSD X reported she was responsible for completing the advanced directives and stated that R34's current DNR, dated 09/15/22, in the EHR lacked a physician's signature. During an interview on 08/14/25 at 04:30 PM, Administrative Nurse D reported that she expected the DNRs to be signed by the physician. The facility's policy "Advanced Directives" dated	F0578		

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F0578 SS = D	Continued from page 3 06/2025 documented it is the policy of Ascension Living to inform residents/resident representatives about Advance Directives, to assist those who wish to complete Advance Directives, honor choices identified in the Advance Directives, and to maintain records in accordance with federal, state law, and community policy.	F0578		
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem	F0582		

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F0582 SS = D	Continued from page 4 rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 32 residents. The sample included 12 residents. Based on interview and record review, the facility failed to ensure the correct and complete Beneficiary Protection Notification forms were issued to one of three residents reviewed, Resident (R) 27. This placed the resident at risk for uninformed decisions. Findings included: - On 08/13/25 a review of the "Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage Form CMS-20052" (SNF ABN) revealed the facility lacked a completed form for R27. R27's "Notification of Medicare Non-Coverage Form 10123""(NOMNC- the form used to notify Medicare A participants of their rights to appeal and the last covered date of service) was signed on 05/21/25. Last covered day of service was 05/23/25. R27 remained in the facility for long-term care. R27's 05/08/25 "Progress Note" at 01:48 PM documented R27 was admitted from hospital for skilled nursing care/rehab. R27's 05/23/25 "Physical Therapy Discharge Summary" documented R27 was discharged from physical therapy to reside in this long-term care facility. Goal partially met with level of assistance with the use of a front-wheeled walker, stand-stepping with cues for safety awareness to decrease risk for falls. During an interview on 08/13/25 12:45 PM, Administrative Staff A reported she could not locate the SNF ABN for R27 and would continue to try to locate the form. Administrative Staff A reported she expected to have required ABNs completed prior to discharge from therapy.	F0582		

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F0582 SS = D	Continued from page 5 The facility did not provide a policy on Beneficiary Protection Notifications.	F0582		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F0605		

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F0605 SS = D	Continued from page 6 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are	F0605		

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F0605 SS = D	Continued from page 7 limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 32 residents. The sample included 12 residents, which included five residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure that Resident (R) 34's as-needed antianxiety (a class of medications that calm and relax people) medication had a 14-day stop date, or a specified duration, and physician rationale for the extended duration. This deficient practice placed the affected resident at risk for adverse effects associated with the use of psychotropic (alters mood or thoughts) medications. Findings included: R34 's Electronic Health Record (EHR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The 11/05/24 "Annual Minimum Data Set" (MDS) documented resident had a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS recorded no behaviors. R34 was totally dependent on staff with activities of daily living (ADL), including bathing, toileting, dressing, footwear, transfers, and personal hygiene. The MDS recorded R34 required maximal assistance with oral care and moderate assistance with eating. The MDS recorded R34 received an antianxiety and antidepressant (class of medications used to treat mood disorders) on a routine basis. The 11/07/24 “Psychotropic Drug Use Care Area	F0605		

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F0605 SS = D	Continued from page 8 Assessment" (CAA) documented R34 had significant behaviors and remained on multiple medications to help manage. Staff would continue to monitor for behaviors and undesired effects related to her medication. The CAA noted R34 was on hospice services at that time, and she was anticipated to have a decline in all care areas. The 05/06/25 "Quarterly Minimum Data Set" documented the resident had a BIMS score of zero. R34 was dependent on staff assistance with all ADLs. The MDS recorded R34 received antianxiety and antidepressant on a routine basis, and no behaviors. R34's "Care Plan" documented interventions on 10/16/24, which directed staff to monitor behaviors and observe for patterns or triggers. Staff were instructed to redirect and remove R34 from overstimulation, offer snacks, or take her to the restroom. The plan instructed staff to monitor and document the effectiveness of mood enhancement medications. Staff were instructed to intervene as necessary to ensure the safety of the resident and others. The plan directed staff to administer medications as ordered and monitor for effectiveness and adverse side effects. Staff were instructed to talk with R34 in a calm voice when her behavior was disruptive and redirect the resident with the above interventions if the resident was crying and upset. The plan noted an intervention dated 06/11/25, which directed staff to continue as-needed (PRN) lorazepam (anti-anxiety medication). R34s "Physician's Orders" documented an order for Ativan (lorazepam) 0.5 milligram (mg), give 0.5mg by mouth every four hours PRN for anxiety/restlessness, date ordered 11/04/24. The order lacked a stop date or specified duration. R34's "Medication Regimen Review" (MRR) reviewed from 01/30/25, documented R34 had an as-needed lorazepam order, and no rationale and duration was noted. The MRR recommended to discontinue the PRN lorazepam, as it was past the 14-day limit per Centers for Medicare & Medicaid Services (CMS). The MRR noted if the lorazepam was to continue, a face-to-face rationale for continued need and expected duration was required. A "Physician Response" to the MRR dated 02/17/25 during a face-to-face visit documented the PRN lorazepam was for an expected duration greater than six months for a rationale of anxiety and agitation: R34 yelled and had increased anxiety. The response lacked a specified duration.	F0605		

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F0605 SS = D	Continued from page 9 R34's "Physician Progress Note" dated 02/17/25 lacked documentation regarding the PRN lorazepam. R34's "Behavior Progress Notes" reviewed from 02/01/25 through 08/14/25, R34 had three documented episodes of uncontrolled crying and laughing episodes that required no PRN medications. During an observation on 08/13/25 08:50 AM, R34 sat in her high-back wheelchair. She wore a right-hand splint. During an interview on 08/14/25 at 07:39 AM, Certified Nurse Aide (CNA) M reported R34 had no behaviors and stated that R34 laughed and smiled quite often. During an interview on 08/13/25 at 10:00 AM, Licensed Nurse (LN) G reported that R34 was in hospice, and she did not require a stop date for her as-needed lorazepam. During an interview on 08/13/25 at 01:17 PM, Administrative Nurse D reported that R34 was a hospice resident and did not require a stop date for the lorazepam. She also reported that the consulting pharmacist would recommend a stop date and believed that R34's physician had completed a face-to-face in February 2025. The facility's policy "Psychotropic Medication" dated 06/2025 documented Psychotropic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. The need to continue as-needed orders for psychotropic medications beyond the 14 days requires the practitioner document the rationale for the extended order and the specific duration of the as-needed order.	F0605		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider	F0628		

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F0628 SS = D	Continued from page 10 must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be	F0628		

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F0628 SS = D	Continued from page 11 endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email	F0628		

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F0628 SS = D	Continued from page 12 address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or	F0628		

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F0628 SS = D	Continued from page 13 therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: The facility had a census of 32 residents. The sample included 12 residents, with one resident reviewed for hospitalization. Based on interview and record review, the facility failed to provide a written bed hold policy and failed to issue a written notification as soon as practicable for transfers of Resident (R) 39. This placed the resident at risk for impaired rights related to returning to the facility. Findings included: Review of the Electronic Health Record (EHR), documented R39 had diagnoses acute hypoxia (a condition characterized by a relatively sudden onset inadequate supply of oxygen that are usually severe), and respiratory failure (a condition where the lungs can't adequately provide enough oxygen to the body or remove enough carbon dioxide, leading to potentially dangerous levels of oxygen and/or carbon dioxide in the blood). R39's 05/17/25 "Entry Minimum Data Set" (MDS) documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R39 was totally dependent on staff for transfers, toileting, and lower-body dressing. The MDS	F0628		

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F0628 SS = D	Continued from page 14 documented R39 required oxygen and bilevel positive airway pressure (BiPAP- a noninvasive ventilator that helps breathing). R39's 05/17/25 "Progress Note" at 11:56 PM documented R39's family requested R39 be transferred to the hospital for an evaluation. R39's EHR lacked evidence the facility provided a bed hold notice or written notification of the transfer to R39 and/or his representative. During an interview on 08/14/25 at 01:54 PM, Licensed Nurse (LN) H reported that she would complete a bed hold form and would have the family or resident sign the form if they could. LN H said if the transfer was emergent, the bed hold form would not be completed. During an interview on 08/14/25 at 01:57 PM, Social Service Designee (SSD) X reported Administrative Staff B, the Business Office Manager (BOM), would complete a bed hold form when a resident transferred to the hospital. During an interview on 08/14/25 at 02:02 PM, Administrative Staff B reported she would only do a verbal bed hold over the phone with the responsible party or the resident when they transferred to the hospital. Administrative Staff B said nursing would provide the bed hold form; however, the form did not state the cost of the room. Administrative Staff B reported she did not have a completed bed hold for R39. During an interview on 08/14/25 at 02:30 PM, Administrative Staff A stated the expectation was for staff to complete a bed hold for every transfer. Administrative Staff A said if the transfer was an emergency, staff would send it to the family the next business day or call them for a bed hold. Administrative Staff A said the nurse also sends a bed hold with the resident when they go to the hospital, but there is no rate on the form, and the resident or the responsible party could call the facility if they want to do a bed hold. The facility's policy "Bed-Holds and Returns" dated 01/2024, documented at the time of transfer for hospitalization or therapeutic leaves, the nursing facility must provide to the residents or resident representatives written notice which specifies the duration for the bed hold. The current bed-hold and return policy established by the state (if applicable) will apply to residents in the community. Prior to a transfer, written information will be given to the	F0628		

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F0628 SS = D	Continued from page 15 residents and the resident representatives that explains the duration of the bed-hold, the reserve bed payment policy as indicated by the state plan, and the details of the transfer.	F0628		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §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: The facility had a census of 32 residents. The sample included 12 residents. Based on observations, interviews, and record review, the facility failed to provide services to meet professional standards of care when staff signed a treatment order as completed but did not complete the treatment for Resident (R) 15. This placed the resident at risk for delayed healing and infection. Findings included: - R15 's Electronic Health Record (EHR) revealed diagnoses of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R15's 05/27/25 "Annual Minimum Data Set" (MDS) documented a Brief Interview of Mental Status (BIMS) score of seven, which indicated severely impaired cognition. The MDS documented R15 required moderate assistance for bathing, toileting, lower body dressing, and footwear. The MDS documented R15 had one venous stasis ulcer (lesion of the lower leg due to poor circulation) and required a non-surgical dressing and application of ointment/medication. R15's 06/03/25 "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) documented R15 continued on multiple restorative programs to maintain the resident's level of function. R15's 06/03/25 "Cognitive Loss/Dementia CAA" documented R15 required prompting throughout the day for	F0658		

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F0658 SS = D	Continued from page 16 activities and when to complete activities of daily living (ADLs). R15's 10/01/24 "Care Plan" documented R15 was anticipated to have persistent and/or recurring wounds to both lower extremities related to diabetes and lymphedema (swelling caused by accumulation of lymph). R15's 06/16/25 "Care Plan" documented staff were to provide treatment as ordered. R15's "Physician Orders" ordered the wounds to anterior(front) left lower extremity, medical (towards the middle) right lower extremity, and right medial ankle were cleansed with wound cleanser and soaked gauze for 10 minutes, then apply Skin-prep (liquid skin protectant) to peri-wound (skin surrounding the wound), apply Opticell AG (antibacterial wound dressing) to wound bed, cover with pad dressing, secure with kerlix and tape, change daily and as needed until resolved, dated ordered 06/21/25. R15's 08/13/25 "Treatment Administration Record" documented that Licensed Nurse (LN) G signed off completed treatment at 01:36 PM in the EHR for both lower extremities' wound care. During an observation on 08/13/25 at 09:38 AM, R15 pulled down her dressing on her left leg. Observation revealed serosanguineous (semi-thick blood-tinged) drainage on the dressing as she pulled it towards her left foot from her knee. R15 then scratched at the area, removed the ace wrap, and placed the dressing and wraps on the dining room table. Certified Nurse Aide (CNA) M walked by R15 two times but did not intervene. During an observation on 08/13/25 at 10:10 AM, CNA N removed the ace wrap and dressing from the dining room table and took them to R15's room; the tablecloth remained on the table. CNA N reported that R15's dressing was still intact on R15's legs. During an observation on 08/13/25 at 01:55 PM, R15 sat in the dining room for lunch, then for an activity. Her left lower leg dressing remained off, and serosanguinous drainage remained on her left leg. During an interview on 08/13/2025 04:12 PM, CNA O reported that if a wound was missing a dressing, the staff would let the nurse know. During an interview on 08/13/225 at 04:51 PM LN G reported she signed off the order for R15's lower extremity treatment earlier that day, around 01:30 PM,	F0658		

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F0658 SS = D	Continued from page 17 and confirmed she had not completed the wound treatment even though she signed it as completed. LN G reported she was not aware that R15 had taken the dressing off her left leg earlier that day. LN G reported that the wound treatment was ordered for 08:00 AM daily and went on to say, “that ship has not sailed yet” and “I don't know why they schedule treatments for that time as we cannot get those done at 08:00 AM” LN G reported she was too busy administering medications and would get the treatment completed before she left today. During an interview on 08/13/25 at 05:00 PM, Administrative Nurse F said she expected the staff to sign off on an order only after it was completed. The facility’s policy “Guidelines for Charting and Documentation,” dated 01/2024, documented that services provided to the resident, or changes in the resident's medical or mental condition, shall be documented in the resident's medical record. A legal record that protects the resident, care providers, and the community. Entries shall reflect the date, the time, and the signature and title of the person recording the data.	F0658		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §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: The facility reported a census of 32 residents. The sample included 12 residents with one dependent resident reviewed for activities of daily living (ADLs). Based on observation, interviews, and record review the facility failed to provide ADL care including grooming of facial hair for Resident (R) 9. This placed the resident at risk for impaired dignity and poor hygiene. Findings included: - R9's Electronic Health Record (EHR) revealed diagnoses of Parkinson’s disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).	F0677		

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F0677 SS = D	Continued from page 18 R9's 11/26/24 "Annual Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS noted R9 required set-up assistance for personal hygiene and oral care. The MDS noted R9 required moderate assistance with toileting, standing, and transfers. The 12/05/24 "Functional Abilities (Self-Care and Mobility) Care Area Assessment" (CAA) documented R9 continued occupational therapy and has been on and off therapy for a significant amount of time. With the progression of his Parkinson's, R9 was anticipated to continue to decline in function, which may be significant if he or his representative decide to discontinue therapy services; there may be a decline despite therapy interventions as well. The 05/27/25 "Quarterly MDS" documented a BIMS of 12, R9 required supervision with bathing and walking. R9 was independent in the remainder of ADLs. R9's “Care Plan” documented an intervention dated 06/06/24, which directed the resident required limited assistance from one of the staff with “HYGIENE/ORAL CARE.” The plan lacked direction related to having or removal of facial hair. R9's “Point of Care” documentation for tasks documented R9 had a shower completed on 08/02/25 and 08/06/25, and R9 required total assistance. A “N,” which indicated no, was documented under showers from 08/07/25 through 08/17/25. R9's “Point of Care” documentation for facial hair removal tasks from 08/01/25 through 08/14/25 was documented as “Y,” which indicated yes. The task directed staff to check and trim facial hair as necessary. R9's “Point of Care” documentation for refusal of care from 08/01/25 through 08/14/25 was documented as “N”. During an observation on 08/12/25 at 11:32 AM, R9 had prominent beard stubble on his face as he sat in the	F0677		

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F0677 SS = D	Continued from page 19 dining room for his lunch. During an observation on 08/14/25 at 07:30 AM, R9 was at the dining room table eating breakfast. R9 still had prominent beard stubble on his face. During an interview on 08/12/25 at 02:31 PM, R9 reported he wished he could shave himself and stated he would not do well because his hands shake. He stated he would need help from the staff. During an interview on 08/14/25 at 07:46 AM, CNA M reported residents were offered shaves on their bath days. During an interview on 08/14/25 at 10:50 AM, CNA N reported R9 could not shave himself; he would be shaved on shower days. CNA N said, R9 was showered and shaved on that day. CNA N stated staff should offer R9 a shave or shave him when requested. During an interview on 08/14/25 at 02:27 PM, Administrative Nurse F reported R9 would refuse a shower often. She expected staff to offer and complete facial hair on residents who required assistance. Administrative Nurse F reported that R9's personal hygiene for shaving was not addressed on his care plan. Administrative Nurse F reported that a "Y" charted in point of care documentation in HER would be a yes that the facial hair was completed when she reviewed the CNA documentation in EHR. The facility's policy "Shaving the Resident" dated 01/2024 documented the purpose of this procedure was to promote cleanliness and provide skincare. Review the resident's care plan to assess for any special needs of the resident. Document the date and time of the shave, and how the resident participated in the procedure.	F0677		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 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	F0684		

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F0684 SS = D	Continued from page 20 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: The facility reported a census of 32 residents; the sample included 12 with five residents reviewed for unnecessary medications and related monitoring. Based on observation, interview, and record review revealed the facility failed to monitor and respond to Resident (R)14 and R36 for lack of bowel movements. This placed the residents at risk for complications including constipation and bowel obstruction. Findings included: - R14's Electronic Health Records (EHR), under the "Physician Orders" (POS), documented diagnoses which included dementia (a progressive mental disorder characterized by failing memory and confusion), hypothyroidism (a condition characterized by decreased activity of the thyroid gland), hypovolemia (abnormally low circulating blood volume), and constipation (difficulty passing stools), R14's 4/15/25 "Annual Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of nine, indicating moderate cognitive impairment. The MDS noted R14 was frequently incontinent of bowel, without a toileting program, and/or constipation. The “Urinary Continence and Indwelling Catheter Care Area Assessment” (CAA), dated 04/20/25, documented the resident was incontinent of bowel and bladder. She did not usually know when she needed to be toileted. R14's "Care Plan" dated 7/13/25, directed staff to provide check and change for incontinent episodes. R14's POS listed in the EHR documented the resident had an order for MiraLAX Powder (laxative), 17grams (gm)/scoop, by mouth, daily, mixed in 8eight ounces of water or liquid for constipation ordered 10/29/24. Review of R14's bowel movement frequency in the EHR dated 07/16/25 through 8/14/25 revealed the resident exceeded three days/72 hours without a bowel movement and/or treatment from 07/26/25 through 08/02/25 (seven consecutive days).	F0684		

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F0684 SS = D	Continued from page 21 On 08/12/25 at 01:48 PM, R14 sat at the dining room table adjacent to her room. She verbalized no concerns. On 08/14/25 at 08:30 AM, Licensed Nurse (LN) H administered R14's morning medication. She confirmed the resident was taking routine medications to treat constipation, but frequently refused her medications. LN H stated the administrative nursing staff generated a report daily to inform the nursing staff of residents that failed to have a bowel movement every three days. She stated when staff were made aware of the lack of a bowel movement within that timeframe, the nurses should initiate interventions to treat constipation, which included an assessment and Milk of Magnesium (laxative- a substance that eases the passage of stool). On 08/14/25 at 09:46 AM, Certified Nurse Aide (CNA) P reported sometimes R14 would refuse care. CNA P stated the CNAs should notify the nurse if the resident does not have a bowel movement during the shift, and document it in the EHR. She reported she was not aware R36 had issues with constipation. CNA P said the administrative nursing staff created a report for the nurses to monitor the frequency of bowel movements, and the nurses then initiated treatment if the resident did not have a bowel movement in three days. On 08/14/25 at 10:53 AM, Administrative Nurse D confirmed R14 lacked a bowel movement as noted above, which exceeded the three-day period where she would expect the nursing staff to intervene and initiate treatment in accordance with the standard of care. Administrative Nurse D stated staff should initiate interventions of assessment of bowel sounds and, if indicated, initiate prune juice followed by milk of magnesia, and if no results, staff should notify the physician to obtain orders for continued treatment as indicated. She stated the facility lacked a formal protocol with standing orders to follow up on residents without bowel movements for three consecutive days/72 hours. Administrative Nurse D confirmed R36 received a routine daily order to prevent constipation, which the facility should monitor for effectiveness. On 08/14/25 at 11:43 AM, Administrative Nurse F said she ran a daily report to determine when residents lacked a bowel movement for 72 hours/three days, which she reviewed with the nurses who then were expected to follow up with the provider and initiate treatment. Administrative Nurse F said there was not a system in place to ensure monitoring of bowel movement frequency when she was off two days a week, on vacation, or for our consecutive days off, as was the case on the dates noted above. Additionally, she confirmed R 36 received	F0684		

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F0684 SS = D	Continued from page 22 scheduled medications, which had adverse side effects of constipation the facility should monitor. The facility did not provide a policy to address the monitoring of residents to prevent constipation. - R36's Electronic Health Records (EHR), under "Physician Orders" (POS), dated 07/16/25, documented diagnoses which included pain, hypothyroidism (a condition characterized by decreased activity of the thyroid gland), and constipation (difficulty passing stools). R36's 04/01/25 "Annual Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating cognitively intact. The MDS noted she required supervision or touching assistance of staff with toilet transfers and partial/moderate assistance of staff for toileting hygiene. She was frequently incontinent of bowel, without a toileting program, and/or constipation. She was occasionally incontinent of bowel without constipation. The resident received scheduled and as-needed (PRN) pain medication, which included opioids (strong narcotic to treat pain). R36's 07/01/25, “Quarterly MDS,” documented changes in assessment of the BIMS score of 14, indicating cognitively intact, and the resident was always continent of bowel. The “Care Area Assessment” (CAA)documentation, dated 04/09/25, included the resident was incontinent of bowel and bladder. R36's "Care Plan" dated 06/26/25, documented staff should administer medications as indicated and monitor for effectiveness and side effects, which included constipation. The plan directed staff R36 required two staff for support for toileting and to offer prompted toileting every two to three hours while the resident was awake; check and change every two hours while sleeping at night. R36's POS, dated 07/16/25, documented the following ordered medications for treatment of constipation: MiraLAX (dissolvable laxative) 17-gram, oral packet, by mouth, daily, for constipation ordered 10/16/24 Probiotic Formula (dietary supplement for digestive health) one billion-25, by mouth, daily, for constipation	F0684		

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F0684 SS = D	Continued from page 23 R36's POS dated 07/16/25 documented the following physician-ordered medications with side effects, which included constipation Tramadol (pain medication) 50 milligrams (mg) tablet, by mouth, every eight hours for pain, ordered 02/19/25. Lasix (used to promote the formation and excretion of urine) 20 mg, by mouth, daily for edema (swelling), ordered 03/18/25 Calcium Carbonate (dietary supplement) 500 mg, by mouth, twice a day for supplement, ordered 12/21/24. Oxycodone (opioid medication) 5.0 mg tablet, by mouth, daily PRN for pain, ordered 12/02/23 Review of R36's bowel movements from 07/16/25 through 8/14/25 revealed the resident had more than three days/72 hours without a bowel movement and/or treatment on 07/23/25 through 07/27/25 (four consecutive days) and 07/31/25 through 08/04/25 (four consecutive days). Review of the “No BM 9 shifts (8-hour shifts) communities” report revealed the facility lacked a report for 07/23/25 through 07/27/25, and 08/01/25 through 08/03/25, to notify the nursing staff of the resident with episodes of no BM for nine shifts/ 72 hours/three consecutive days on those occasions. On 08/12/25 at 01:53 PM, R36 sat in her chair in her room. R36 stated she had no complaints of pain. She reported she usually knew when she needed to go to the bathroom and said staff checked on her and would help her when she needed to use the toilet. On 08/14/25 at 9:46 AM, Certified Nurse Aide (CNA) P stated CNAs should notify the nurse if the resident does not have a bowel movement during the shift and document in the EHR. She reported she was not aware R36 had issues with constipation. CNA P said the administrative nursing staff created a report for the nurses to monitor the frequency of bowel movements, and the nurses then initiated treatment if the resident did not have a bowel movement in three days. On 08/14/225 at 10:53 AM, Administrative Nurse D confirmed R36 lacked a bowel movement as noted above, which exceeded the three-day period where she would expect the nursing staff to intervene and initiate treatment in accordance with the standard of care. Administrative Nurse D stated staff should initiate interventions of assessment of bowel sounds and, if indicated, initiate prune juice followed by milk of	F0684		

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F0684 SS = D	Continued from page 24 magnesia, and if no results, staff should notify the physician to obtain orders for continued treatment as indicated. She stated the facility lacked a formal protocol with standing orders to follow up on residents without bowel movements for three consecutive days/72 hours. Administrative Nurse D confirmed R36 received a routine daily order to prevent constipation, which the facility should monitor for effectiveness. On 08/14/25 at 11:43 AM, Administrative Nurse F said she ran a daily report to determine when residents lacked a bowel movement for 72 hours/three days, which she reviewed with the nurses who then were expected to follow up with the provider and initiate treatment. Administrative Nurse F said there was not a system in place to ensure monitoring of bowel movement frequency when she was off two days a week, on vacation, or for our consecutive days off, as was the case on the dates noted above. Additionally, she confirmed R 36 received scheduled medications, which had adverse side effects of constipation the facility should monitor. The facility did not provide a policy to address the monitoring of residents to prevent constipation.	F0684		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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;	F0880		

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F0880 SS = D	Continued from page 25 §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 conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by:	F0880		

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F0880 SS = D	Continued from page 26 The facility reported a census of 32 residents. The sample included 12 residents. Based on interviews, observation and record review, the facility failed to utilize Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) when providing direct care to a Resident (R) 42 with a peripherally inserted central catheter (PICC-a thin, flexible tube that is inserted into a vein in the upper arm and threaded into a large vein above the heart). The facility further failed to ensure adequate hand hygiene during personal care for R3 when staff failed to complete proper hand hygiene. The facility failed to store respiratory equipment in a sanitary manner for R6. These deficient practices had the potential to spread infections to the residents in the facility. Findings included: - Observation on 08/12/25 At 11:54 AM, R6 had oxygen tubing dated 08/03/25 stored in a plastic bag attached to an oxygen concentrator. The plastic bag had a large hole noted on the bottom and side of the bag and the plastic bag laid on R6's floor. Observation on 08/12/25 at 11:59 AM, Certified Nurse Aide (CNA) P provided peri-care to R3. CNA P removed her gloves and applied a clean pair of gloves, but did not perform hand hygiene prior to donning the clean gloves. Observation on 08/13/25 at 09:32 AM, Licensed Nurse (LN) H, applied gloves but no gown, then administered Cefazoline (antibiotic) 2 grams (gm), 100 milliliters (ml) normal saline, every 8 hours for sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body) via intravenous (IV-administered directly into the bloodstream via a vein) to R42 through the PICC line. LN H stated she should have worn a gown when providing care to resident on EBP. Observation on 08/13/25 at 10:03 AM, CNA N provided peri-care to R15. CNA N removed her glove from her right hand in between the dirty and clean during peri-care provided and applied a new glove to her right hand without performing hand hygiene. CNA N stated she should have removed both gloves and performed hand hygiene between clean and dirty actions of the task. Observation on 08/13/25 at 10:19 AM, R6 had oxygen tubing dated 08/03/25 stored in a plastic bag attached to an oxygen concentrator. The plastic bag had a large	F0880		

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F0880 SS = D	Continued from page 27 hole noted on the bottom and side of the bag, and the plastic bag laid on R6's floor. Observation on 08/13/25 at 10:23 AM, LN H disconnected R42's IV. She removed her gown, but her gloves remained on as LN H exited R42's room. LN H closed R42's door with the handle, with gloved hands, and walked into the hallway. LN H stated she should have removed gloves and sanitized hands before leaving the resident's room. During an interview on 08/13/25 at 03:28 PM, Administrative Nurse E, the Infection Preventionist nurse, stated they expected staff to wear all required PPE for all residents that had EBP. Administrative Nurse E stated they expected staff to remove all PPE prior to exiting a resident's room and complete hand hygiene. During an interview on 08/14/25 at 10:55 AM, CNA N reported the oxygen tubing storage bag should not be placed on the floor and should not have several holes in the bag. During an interview on 08/14/25 at 11:30 AM, Administrative Nurse E expected staff to remove both gloves after peri-care was performed, perform hand hygiene before applying new gloves to complete peri-care. Administrative Nurse E expected respiratory supplies to be stored in a bag when not in use, placed off the floor with no holes in the bag. The facility's policy "Standard and Transmission-Based Precautions" dated 06/2025 documented that it is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogen's mode of transmission. Hand Hygiene should be performed immediately before touching a patient, before moving from work on a soiled body site to a clean body site on the same resident, after touching a resident or the resident's immediate environment, and immediately after glove removal. Each community will fully implement Enhanced Barrier Precautions. Shall be implemented during high-contact resident care activities when caring for residents who have an increased risk for acquiring and/or transmitting multiple drug-resistant organisms (MDROs- common bacteria that have developed resistance to multiple types of antibiotics), such as a resident with wounds, indwelling medical devices, and residents with colonization with an MDRO. The facility did not provide a policy on the care of respiratory supplies.	F0880		