STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075414	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havencare at Hancock Hall	31 Staples St Danbury, CT 06810

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, and interviews for 1 of 3 sampled residents (Resident #57) reviewed for abuse, the facility failed to ensure a resident was treated in a respectful and dignified manner. The findings include: Resident #57 had diagnoses that included dementia and anxiety disorder. The quarterly MDS assessment dated [DATE] identified Resident #57 was moderately cognitively impaired and required one person assist with bed mobility, and two persons with transfers. The care plan dated 2/4/25 identified Resident #57 had the potential for mood changes related to dementia and was at risk for functional deficits. Interventions included to assist with positive coping skills and help with ADL activities. Physician orders are directed to provide a mechanical (2 person) transfer and assist of one with bed mobility. The nurse's note dated 4/24/25 at 2:30 PM identified at 1:00 PM, Resident #57 reported earlier that morning, s/he was spoken to in an inappropriate manner by a staff member, NA #1. An allegation of verbal abuse had been initiated following the interview. A facility reported event dated 4/24/25 at 2:38 PM identified at 1:00 PM, Resident #57 reported NA #1 called her a rich bitch and s/he did not appreciate the interaction. The physician, police, family and social services were notified. Psychiatry services were contacted with a telehealth evaluation. NA #1 was immediately placed on administrative leave pending the outcome of the investigation. An interview with NA #1 on 4/29/25 at 9:25 AM identified she was assigned to Resident #57 during the 7:00 AM to 3:00 PM shift on 4/24/25. NA #1 identified she and NA #2 were assisting Resident #57 to get ready for a hair salon appointment. During routine conversation, NA #1 stated to Resident #57 that s/he was a rich woman and needed to spend h/her money and feel good about h/herself. At the time, Resident #57 seemed happy and unbothered by the comment. NA #1 was later informed of the concern and was removed from the schedule. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with NA #2 on 4/29/25 at 10:41 AM identified she was working during the 7:00 AM to 3:00 PM shift on 4/24/25 when NA #1 requested assistance in preparing Resident #57 for a hair salon appointment. NA #2 identified she and NA #1 were talking to Resident #57 who seemed happy and cheerful. NA #2 identified she observed and heard NA #1 give Resident #57 a hug from behind stating s/he was rich, so spend h/her money. An interview with the Administrator on 4/30/25 at 12:36 PM identified while abuse was unsubstantiated following the completion of the investigation, NA #1 provided education in customer service, perception of reality and handling feedback. An interview with the DNS on 5/01/25 at 10:48 AM abuse was not substantiated in this case but would expect all residents to be treated with respect and dignity. A review of the facility policy for Resident Rights directed the facility to uphold that all residents be treated with respect, dignity and compassion.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record and policy review for 1 of 3 residents (Resident #58) sampled for abuse, the facility failed to protect a resident from physical abuse. The findings included: Resident #58's diagnoses included Alzheimer's disease, unspecified psychosis and pseudobulbar affect. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #58 was severely cognitively impaired, required set up help with eating and was dependent on staff for transfers and dressing. The Resident Care Plan dated 2/4/25 identified Resident #58 had a potential risk for behaviors due to delusions. Interventions included identifying behaviors, redirecting as needed and monitoring for target behaviors. A nurse's progress note dated 4/5/25 at 3:00 PM identified that during lunch Resident #58 was self-propelling in a wheelchair and attempted to take a spoon from another resident, then hit the other resident. Staff intervened and Resident #58 was immediately removed from the vicinity and placed on 1:1 monitoring. Resident #58 was calm with no signs of agitation, and unable to recall the events. 2. Resident #5's diagnoses included Alzheimer's disease, dementia, and hypothyroidism. The quarterly MDS assessment dated [DATE] identified Resident #5 was moderately cognitively impaired, required set up help with eating and partial/moderate assistance for transfers and dressing. The March 2025 Resident Care Plan identified Resident #5 was at risk for cognitive/communication decline from baseline related to a diagnosis of Alzheimer's disease, dementia with behavioral disturbances and psychosis. Interventions included asking simple questions/requesting clarification as needed and encouragement to participate in facility activities for socialization. A nurse's progress note dated 4/5/25 at 3:00 PM identified Resident #5 was struck upon his/her cheek during lunch. There was no discoloration, redness, or swelling to his/her right check and Resident #5 was jovial, denying any feelings of anger, sadness or fear. The Accident and Incident Report dated 4/5/25 at 2:00 PM identified that on 4/5/25 at 1:10 PM Resident #58 hit another resident (Resident #5) during lunch while in the second-floor dining room. A psychiatric evaluation and consultation assessment dated [DATE] identified that Resident #58 was not considered a danger to self or others. The summary of the report to the state agency on 4/8/25 at 12:00 AM identified that on 4/5/25 at approximately 1:10 PM, there was witnessed resident to resident altercation without injury. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #58 was observed propelling his/her mobility device within the dining room. Resident #58 approached the seating area of Resident #5 and reached for his/her spoon. Per the witness, Resident #5 placed his/her hand over the spoon to prevent Resident #58 from taking it. Subsequently, Resident #58 slapped Resident #5 on the right cheek. Staff members who witnessed the incident immediately intervened, Resident #58 was promptly removed from the dining room area and placed on continuous (1:1) observation. An investigation was initiated, the MD, the local police department and the POAs of both residents. Both residents were assessed by Psychiatry services immediately via telehealth - neither resident had any recollection of the incident. Interview with Nurse Aide (NA) # 4 on 5/1/25 at 10:20 AM identified on 4/5/25 she was in the dining room at lunch time passing out coffee and Resident # 58 was wheeling around the dining room like she usually does, he/she gets weepy sometimes so instead of redirecting him/her immediately, they wait until lunch is served. NA #4 saw Resident #58 trying to grab a spoon that was in front of Resident #5. Resident #5 started to say something along the lines of its mine and without any notice Resident #58 slapped Resident #5 on the cheek. NA #5 stood up but couldn't get there in time. Additionally, NA #4 identified Resident #58 does not have a history of hitting, and both residents forgot about the incident quickly. Interview with NA #5 on 5/1/25 at 10:47 AM identified that on 4/5/25 she was in the dining room, Resident #58 was self-propelling around the room, then approached Resident #5, grabbed his/her utensil off the table and as Resident #5 started to say something, Resident #58 slapped him/her on the cheek. NA #5 identified she has never seen that behavior from Resident #58, nor has she in since the incident. Review of the Abuse, Neglect and Exploitation Policy directed in part that the facility is committed to providing a safe and respectful environment that supports the health and well-being of all people receiving services. Additionally, physical abuse includes but is not limited to hitting, slapping, punching, kicking, and biting.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations, facility documentation, facility policy and interviews for 1 of 3 sampled residents (Resident #61) reviewed for pressure ulcer, the facility failed to ensure an initial comprehensive skin assessment was completed for a newly identified skin condition and failed to regularly assess a resident's weight to ensure a pressure-relieving mattress adjusted according to manufacturer guidelines and for for 1 of 3 residents (Resident #72) reviewed for pressure ulcer/injury, the facility failed to maintain air mattress settings according to manufacture guidelines. The findings included: 1.Resident #61's diagnoses included dementia and protein calorie malnutrition. The quarterly MDS assessment dated [DATE] identified Resident #61 had severely impaired cognition, required two persons assist with bed mobility and transfers, and had no unhealed pressure ulcers. The care plan dated 2/18/25 identified Resident #61was at risk for skin impairment and altered nutritional status related to dementia and protein calorie malnutrition. Interventions included reporting any skin breakdown and monitor weights. a. Nursing progress note dated 3/15/25 at 11:29 AM identified a small irritation to the coccyx area. A zinc-based ointment was applied, and the nursing supervisor was made aware. The Advanced Practiced Registered Nurse (APRN) was to evaluate. The responsible party was notified. The Wound APRN Communication book dated 3/15/25 noted Resident #61 needed an evaluation of the buttock region. The physician's orders dated 3/17/25 directed Triad paste for redness every shift. The Wound APRN Communication book dated 3/17/25 noted Resident #61 had redness and an open area on the buttocks. Orders for triad paste were obtained. However, the area needed wound orders. A Wound specialty progress note dated 3/19/25 identified a consultation was requested for Resident #61 with reported wounds to the sacral area. Two wounds were identified, one on the left sacrum measuring 2.4 Centimeter (CM) x2.0 CM x 0.1 CM and another on the right measuring 1.0 CM x 1.0 CM x 0.1 CM. Both wounds were pink, granular with a small amount of serosanguineous drainage consistent with stage two pressure injuries. An interview and clinical record review with APRN #2 on 4/28/25 at 2:50 PM identified she provided wound consultations for the facility. APRN #2 identified she began seeing Resident #61 on 3/19/25 for newly identified wounds and has continued consultations on a weekly basis for one remaining wound. An interview with the Director of Nursing Services (DNS) on 4/28/25 at 3:20 PM identified he was unable to verify who was responsible for the facility wound tracking, if any wound documentation was maintained separate from the clinical record or if any assessments were completed prior to 3/19/25. The DNS further identified he wound expect an assessment that included color, warmth and measurements to be completed by nursing staff for any change in skin integrity. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview RN #1, regional [NAME] President of Nursing Services, on 4/28/25 at 3:35 PM identified the DNS is responsible for the weekly wound tracking for the facility. A separate wound tracking was maintained and provided by the DNS to APRN #2 on a weekly basis. RN #1 indicated she and the DNS reviewed the electronic communication of the current resident wound list from the DNS to APRN #2 dated 3/18/25 and confirmed Resident #61 was not included on the list, nor was there a documented assessment completed prior to 3/19/25. An interview with LPN #2 on 4/29/25 at 2:31 PM identified she was the assigned nurse during the 7:00 AM to 3:00 PM shift on 3/15/25 when the open area to the buttocks was first identified. LPN #2 indicated she notified the nursing supervisor, RN #5 who came up to the unit and instructed her to add the information to the APRN wound book requesting an evaluation. An interview and facility documentation review with RN #5 on 4/29/25 at 2:36 PM identified she was the assigned nursing supervisor during the 7:00 AM to 3:00 PM shift on 3/15/25. RN #5 identified for any change in condition, she would complete an assessment, notify the physician and responsible party and document the assessment and any actions taken. RN #5 identified she did not complete an assessment for Resident #61 for the newly identified open area as an oversight and that one should have been completed. Although requested, a policy for assessment and management of a newly identified skin injury was not provided. b. The physician's orders dated 3/1/25 directed an air mattress- non static setting at 100lbs.- check placement and proper inflation every shift. The Weight log dated 4/2024 through 4/2025 identified Resident #61 experienced a 25.41% or 18.8lbs. weight loss in one year with a current weight of 74lbs. A review of the clinical record failed to identify documentation the air mattress settings had been regularly assessed to determine if the current settings remained appropriate. An interview and clinical record review with APRN #2 on 4/28/25 at 2:50 PM identified she provided wound consultations for the facility. APRN #2 identified she would expect the facility to ensure the air mattress was set in accordance with manufacturer's guidelines. An observation on 4/28/25 at 3:10 PM with RN #4 identified the air mattress was set to 100lbs. An interview and clinical record review with APRN #3 on 4/30/25 at 9:34 AM identified she provided medical services to and was responsible for prescribing orders for Resident #61. APRN #3 identified Resident #61 had experienced significant weight loss over the past year. APRN #3 indicated she trusted that the staff would review weights at regular intervals to determine if the current air mattress settings remained appropriate and that it was her expectation the settings be set in accordance with manufacturer's guidelines as Resident #61 was unable to express preference. An interview with the DNS on 5/01/25 at 10:48 AM identified he would expect the air mattress to be set in accordance with manufacturer guidelines and preference. If a resident's weight changes, the DNS would expect nursing staff to have a discussion with the APRN to determine the appropriateness of the mattress settings. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the manufactures guidelines for the alternating air loss mattress system recommends determining the patient's weight and setting the control knob to that weight setting on the control unit. A review of the facility policy pressure reducing mattress directed that all residents identified at high risk for skin breakdown or actual pressure area will be provided with an alternating air pressure mattress that is to be checked for proper placement and inflation each shift. 2.Resident #72's diagnoses included fracture of unspecified part of neck of left femur and essential (primary) hypertension. The admission Minimum Data Set assessment dated [DATE] identified Resident #72 was cognitively intact and was dependent for toileting, shower/bath, lower body dressing, and transfers. Additionally, it identified there were two unstageable deep tissue injuries. The Resident Care Plan dated 4/23/2025 identified Resident #72 was at risk for skin impairment related to decreased mobility from left hip fracture, status post left hip hemiarthroplasty, and deep tissue injury to bilateral heels. Interventions included to monitor skin impaired sites for healing/worsening as per facility policy, off and/or encourage frequent turning/positioning for skin integrity and provide pressure relieving devices (mattress/chair cushion) as warranted. A physician's order dated 4/08/2025 for Resident #72 directed to check placement and functions of air mattress every shift. Observation on 4/30/2025 at 6:20 AM, identified that Resident #72 was sleeping in bed. Additionally, it identified that there was an air mattress under the resident and the mattress was set to 200 with normal pressure. Interview with the Wound APRN on 4/28/2025 at 2:50 PM identified the air mattresses should be set according to manufacturer guidelines. Interview, clinical record review, and observation with RN #2 on 4/30/2025 at 7:40 AM, identified Resident #72 was sleeping in bed with the air mattress set to 135. RN #2 stated the air mattress should be set to the residents most recent documented weight and it is the unit nurse responsibility to ensure the correct setting. Review of the clinical record with RN #2 identified the resident's last documented weight was on 4/25/2025 at 106.5 pounds (lbs.). After inquiry, RN #2 adjusted the air mattress setting between the numbers of 80 and 120 on the machine. Interview with the DNS, Administrator, and RN #1 on 4/30/2025 at 8:45 AM identified air mattresses should be set based on resident weight and resident preference per MD order. Additionally, they identified that MD should be notified if set per resident preference. Interview with the Medical Director, MD #1, on 4/30/2025 at 9:26 AM via telephone identified the order for Resident #72 regarding the air mattress did not inform staff of how the air mattress should be set. MD #1 stated that either the nursing staff or Wound APRN would make recommendations for the appropriate settings and the air mattress setting should be to those recommendations. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of operator's manual for Med-Aire Melody alternating pressure low air mattress replacement system identified in the operating instructions section, step six directed to determine the patient's weight and set the control known to that weight setting on the control unit Review of the pressure reducing mattress policy with a revision date of 1/2024 identified that residents with an identified pressure area will be provided with an alternating pressure air mattress. The policy directed the nurse to update MD/APRN of pressure and to obtain physician's order, Additionally, noted the alternating pressure mattress is to be check for proper placement and inflation each shift and as needed.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review and interview for 1of 5 residents (Resident # 36) reviewed for unnecessary medications, the facility failed to address a pharmacy medication/drug regimen review (MRR) regarding a medication in a timely manner. The findings include: Resident # 36's diagnoses included osteoporosis, metabolic encephalopathy and pain. The physician's order dated 2/6/25 directed to apply a Lidocaine External Patch 4 % to the left knee topically one time a day for pain for 12 hours, off at night for 12 hours. The Resident Care Plan dated 3/18/25 identified Resident #36 was at risk for experiencing pain due to age related osteoporosis. Interventions included administering medication and/or treatments per Medical Doctor (MD) orders and monitoring and reporting nonverbal signs and symptoms of pain. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #36 was severely impaired and dependent on staff for dressing, toileting and transfers. The Medication Administration Record identified the Lidocaine External Patch 4 % to be applied to the left knee topically one time a day for pain on for 12 hours, off at night for 12 hours, was signed off as being applied at 6:00 AM, without the benefit of a specified removal time. The Pharmacy Drug Regimen Review dated 3/12/25 directed to please schedule removal of lidocaine patch. and failed to identify a reviewed by signature. Interview and record review with the Director of Nursing (DNS) on 5/01/25 at 10:56 AM identified the DNS is responsible for following up on drug regimen reviews as soon as possible. He could not identify why the 3/12/25 recommendations for Resident #36 were not addressed until after inquiry on 4/30/25 (total of 48 days). The Drug Regimen Review-Monthly Policy directed in part the physician or licensed designee shall respond to the drug regimen review within 7-14 days or more promptly and document on the drug regimen review form whether he/she agrees or disagrees with the recommendations.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation for 1 of 2 medication storage rooms (One North) and staff interview, the facility failed to remove expired medications from the medication refrigerator and failed to ensure the refrigerator temperatures were monitored. The findings included: A tour of the One North medication storage room on 4/25/25 at 12:09 PM with LPN #1 identified the following medications in the refrigerator inclusive of two medications that were expired: 1a. 2 Boxes of Bisacodyl suppositories package of 12 unopened. b. 2 packages of fleet glycerin suppositories (1 unopened the other ¾ full). c. 6 injectors of Toujeo solo star insulin unopened. d. 1 package of Brimonide eye drops 0.15% ophthalmic solution unopened. e. 1 Lyumjev Kwik pen 100 units/milliliters. f. 8 Prevnar 20 vaccines 0.5 milters unopened g. 7 injectors of Trulicity 0.7 milligrams/0.5 milliliters unopened. h. 2 Comirnaty 24-25 vaccines 0.3 milters, both expired 3/15/25 i. 4 Lanotoprost 0.0005% ophthalmic solution 2.5 milters, unopened j. 1 Ceftriaxone 1 gram vial, unopened. k. 1 lidocaine 1% injection, 10 milliliter unopened. l. 2 vyzalta 0.024% 2.5 milliliters, unopened m. 1 insulin aspart 100 units/milliliters unopened (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	n. 14 Abrysvo ADV 120 micrograms (RSV vaccine) unopened. o. 6 vials of expired hepatitis b vaccines (Engerix-B 20 micrograms/milliliter-1milliliter) with an expirator date of 3/15/25. Also, identified in the One North refrigerator in a brown envelope were medications that were used as stock emergency medications which included: a. 4 insulin glargine 100 unit/milliliter pens unopened b. 2 Insulin lispro Kwik pens 100 units/milliliter unopened c. 2 insulin aspart 100 unit/flex pen unopened d. 2 Levemir flex pen 100 units/milliliter unopened Additionally, the refrigerator temperature logs from One North from January 1, 2025, through April 25, 2025, identified the following: The temperature log reviewed from One North refrigerator from January 1, 2025through April 25, 2025, which is a total of 114 days. The following 25 days the refrigerator temperatures were not monitored: 1/6/25,1/7/25,1/9/25 ,1/10/25,1/30/25,1/31/25, 2/1/25, 2/4/25,2/5/25,2/6/25, 2/7/25 ,2/28/25, 3/4/25, 3/7/25, 3/10/25,3/24/24/25, 3/25, 3/26/25,3/31/25, 4/19/25, 4/20/25, 4/21/25, 4/22/25, 4/23/25.4/24/25. b. The temperature log reviewed from January 1, 2025, through April 25, 2025, a total of 74 days out of 114 days the temperature of the One North refrigerator was monitored only 1 time per day. On 4/25/25 at 12:15 PM an interview with LPN #1 identified that outdated or discontinued medications should be immediately removed from stock and given to the Nursing Supervisor and the refrigerator temperature logs are to be completed by the 11:00 PM and 7:00 AM nursing shift. On 4/25/25 at 12:16 PM an interview with RN #1 identified she thought the policy for monitoring refrigerators temperatures was once a day, that checking for expired medication was a nursing responsibility and expired medication should have been removed on a timely basis. After inquiry, RN#1 disposed of all expired vaccines and ran a report which identified no vaccines were administered that had expired. Review of the Policy for Medication Refrigerator Temperature Checks identified the purpose to ensure safe storage of medications and vaccines by maintaining appropriate temperatures, thereby reducing the risk of compromised medication efficacy and patient harm. The policy further identified temperature checks for medication refrigerators will be completed once daily during assigned shifts, vaccines which require stricter monitoring were to be stored in a refrigerator and temperature were to be monitored twice daily. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Policy for Expired Medications identified that all medication carts, cabinets, refrigerators will be routinely checked by nursing personnel, all expired medications will be removed and discarded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075414	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havencare at Hancock Hall	31 Staples St Danbury, CT 06810

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations, facility documentation, facility policy and interviews for 1 of 3 sampled residents (Resident #61) reviewed for pressure ulcer, the facility failed to ensure personal protective equipment (PPE) was worn while providing direct care for a resident on enhanced barrier precautions (EBP) and failed to complete hand hygiene in accordance with current infection control practices while providing incontinent care. The findings include: Resident #61 had diagnoses that included dementia and protein calorie malnutrition. The quarterly MDS assessment dated [DATE] identified Resident #61 had severely impaired cognition, required two people assist with bed mobility and transfers, and had no unhealed pressure ulcers. The care plan dated 2/18/25 identified Resident #61 required assistance with ADL's related to decreased mobility was at risk for skin impairment. Interventions included provide assistance as applicable for ADL activities and assistance of two for transfers. Physician orders dated 3/1/25 directed enhanced barrier precautions related to a history of a multidrug resistant organism meaning staff providing direct care must first don PPE. 1. An observation on 4/28/25 at 2:54 PM of NA #3 identified she was providing incontinent care to Resident #61 without the benefit of PPE. NA #3 indicated she was changing Resident #61's brief. An interview with NA #3 on 4/28/25 at 3:07 PM identified she was supposed to have been wearing PPE while providing direct care but did not as an oversight. An interview with the DNS on 04/28/25 03:20 PM identified he would expect any staff caring for a resident on EBP be wearing PPE if providing direct care to that resident. Although requested a policy for enhanced barrier precautions were not provided. 2. An observation on 4/29/25 at 10:20 AM identified LPN #2 was donned in PPE providing incontinent care to Resident #61 while in bed. LPN #2 was observed cleansing Resident 61's perianal area, who was incontinent with both urine and stool with disposable cloths and cleansing solution. On four separate occasions during incontinent care, LPN #2 removed her gloves, discarded them in the garbage receptacle, move the PPE gown aside to reach into her uniform pocket for new set of gloves and don the new gloves to resume incontinent care without first washing hands before reaching into uniform pocket. An interview with LPN #2 on 4/29/25 at 10:20 AM identified she should have washed her hands each time she removed her gloves and did not state she was nervous. An interview RN #1, regional [NAME] President of Nursing Services, on 4/29/25 at 2:45 PM identified hand hygiene should have been performed after doffing gloves when providing incontinent care. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy for Hand Hygiene directed that hand hygiene be performed either by alcohol-based hand rub or soap and water, be performed before and after glove removal. Gloves were not a substitute for hand hygiene. Hand hygiene was to be performed immediately following the removal of gloves.