STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185482	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Willows at Fritz Farm	2710 Man O War Boulevard Lexington, KY 40515

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview, record review, and facility policy review, the facility failed 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 for 3 of 6 residents reviewed for advance directives, Resident (R) 5, R36, and R42. The findings include: Review of the facility's policy titled, Guidelines for Advance Directives, revised 09/26/2024, revealed its purpose was to ensure the facility's staff obtained and followed residents' advance directives regarding end-of-life care. Further review revealed if a resident had a living will and a durable power of attorney (POA) for health care, these documents would be scanned into the medical record by the admissions representative or designee. 1. Review of R5's Face Sheet revealed the facility admitted the resident on 12/18/2024 with diagnoses including dementia and atherosclerotic heart disease. Further review revealed Family (F) 4 was listed as R5's POA. Review of R5's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 12/27/2024, revealed the the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of one out of 15, indicating the resident was severely cognitively impaired. Review of R5's Electronic Health Record (EHR) revealed documentation of code status only. There was no evidence in the resident's chart the facility had requested and/or received a copy of R5's legal POA document. Also, the facility was unable to provide a copy of R5's legal POA document. In an interview with F4 on 04/03/2025 at 3:49 PM, she stated she was the legal POA for R5. 2. Review of R36's Face Sheet revealed the facility admitted the resident on 02/24/2024 with diagnoses including metabolic encephalopathy, pulmonary fibrosis, and need for assistance with personal care. Review of R36's annual MDS, with an ARD of 02/27/2025, revealed the resident had a BIMS score of 10 out of 15, indicating the resident was moderately cognitively impaired. Review of R36's EHR revealed documentation of code status only. There was no evidence of a living (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will documented or located in the resident's chart. In an interview with R36 on 04/03/2025 at 9:53 AM, she stated all of her decisions would be made by her daughter, but her husband had taken care of their end-of-life paperwork. In an interview with F5, R36's family member, on 04/03/2025 at 11:55 AM, he stated R36 had a living will, and he remembered going over it with the facility when she was admitted . 3. Review of R42's Face Sheet revealed the facility admitted the resident on 02/21/2025 with diagnoses including paralysis of left side following a stroke, osteoarthritis, and personal history of breast cancer. Review of R42's admission MDS, with an ARD of 02/25/2025, revealed the resident had a BIMS score of 13 out of 15, indicating the resident was cognitively intact. Review of R42's EHR revealed documentation of code status only. There was no evidence of a living will or evidence the facility presented living will information to the resident documented in her chart. In an interview with R42 on 04/03/2025 at 11:33 AM, she stated she had a living will but was not sure what it specified. She further stated her son took care of information like that, and he should have provided it. When shown a Living Will Packet, the resident stated it looked familiar. In an interview with the Admissions Coordinator on 04/03/2025 at 2:30 PM, he stated as soon as residents came in to the facility, he obtained their code status, introduced them to staff, and went over each paper in the admission agreement in a way they understood. The Admissions Coordinator stated he asked the resident and/or their POA if they had an advance directive in place, and if they did, he requested a copy so it could be placed in the resident's EHR. He further stated he completed a progress note in the resident's EHR that stated the resident had some type of Advance Directive, and it had been requested. The Admissions Coordinator stated the previous admissions person completed R42's admission, and he did not recall that R36 informed him of an advance directive. The Admissions Coordinator stated they periodically followed up with residents they knew had a living will or POA and just had not brought in a copy. The Admissions Coordinator was unable to be more specific than periodically. In an interview with the Director of Nursing (DON) on 04/04/2025 at 10:14 AM, she stated Admissions completed advance directive paperwork. She further stated if a resident's code status was not signed when they came in, nursing obtained the signature and scanned the documentation into the resident's EHR. The DON stated living will and POA documentation were completed and obtained by the Admission's office. The DON stated they had resident first meetings upon admission where code status and advance directives were discussed. She further stated that information was also discussed at quarterly care plan meetings, where the care plans were reviewed and discussed with staff/family/resident. The DON stated if the resident wanted to change their status that included palliative or hospice care, the doctor became involved, and their living will was addressed at that time as well. In an interview on 04/04/2025 at 11:15 AM, the Executive Director stated residents were given the opportunity upon admission, to make an advance directive if they had not already done so. She further stated they tried to get copies of existing living wills and/or POAs for the residents' medical records. The Executive Director stated if a resident stated they had an advance directive in place, the (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident and family should be interviewed about their wishes at admission, so that information was known and documented until the legal documentation had been received. The Executive Director stated a resident first meeting was held right after admission and advance directives were addressed at that meeting. She further stated the subject was addressed again in quarterly care plan meetings. The Executive Director stated it was important they had regular conversations with the family, especially when a resident's health had declined. The Executive Director stated she talked with F5, and he stated R36's advance directive information was probably in some drawer at home. Additionally, the Executive Director stated communication and follow-up between the facility and the families related to advance directive documentation needed improvement.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of the facility's document and policy, the facility failed to provide a clean, sanitary, comfortable, and homelike environment for 1 of 4 hallways, the 100 Hall. The findings include: Review of the facility's document Trilogy - Kentucky HC admission Packet 10.28.24_Combined, undated, revealed under the Resident Rights section, the resident had the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside of the facility. Review of the facility's policy titled, Urinary Catheter Care, dated 12/16/2024, revealed the facility's staff ensured there was no disconnection or leaking of urine from the catheter system. A policy that addressed homelike environment was requested but not provided. Observation on 04/01/2025 at 9:50 AM revealed a slight smell of urine upon entrance to the facility. Observation on 04/03/2025 at 9:47 AM revealed a strong urine smell in the 100 Hall. Observation on 04/04/2025 at 8:32 AM revealed a urine odor noted in the front lobby near the receptionist's desk which was located at the entrance to the 100 Hall. Observation of room [ROOM NUMBER] on 04/03/2025 at 4:13 PM revealed the Senior Director of Environmental Services (SDEV) had just shampooed the carpet, but it still smelled of urine. In an immediate interview, the SDEV stated the room smelled like urine because a catheter leaked onto the carpet. She further stated the smell might not come out, and the carpet would need to be replaced. In a telephone interview with Family (F) 3 on 04/03/2025 at 3:23 PM, he stated when his family member was a resident at the facility and resided in room [ROOM NUMBER], it was a recurrent issue that his catheter leaked. He further stated, he noted on several occasions when he visited the facility there was a towel on the floor underneath the catheter drainage bag. F3 stated there was a blue plastic bag that went around the catheter bag that kept it from leaking, but it was not always there, and the bag leaked onto the carpet. In an interview on 04/04/2025 at 8:25 AM, Registered Nurse (RN) 4 stated the resident that previously resided in room [ROOM NUMBER] was easily angered, frequently refused catheter care, and refused to let staff change his shorts when they were wet. RN4 stated anytime the resident's catheter drainage bag leaked, it was changed. She further stated Housekeeping cleaned the carpet because of the urine odor that lingered in the room, and it smelled in the hallway as well. In an interview on 04/04/2025 at 8:34 AM, the SDEV stated it was important to clean urine from the carpet so residents felt like their home was clean, and they were in a good facility. In an interview on 04/04/2025 at 8:58 AM, Licensed Practical Nurse (LPN) 2 stated if she noticed a (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's catheter bag leaked and could not determine the cause, she notified an RN to see if it needed to be replaced. She further stated she placed a dignity cover around the drainage bag, so it was contained and kept off the carpet until it was changed. LPN2 stated it was demeaning if a resident lived in a room that smelled like urine, and no one wanted that. In an interview with the Director of Nursing (DON) on 04/04/2025 at 10:14 AM, she stated their goal was the facility was kept free from odors, but incontinence issues were unavoidable. However, she further stated it was her expectation incontinence issues were cleaned immediately, and the carpet replaced if necessary. The DON stated it was initially thought the resident that previously resided in room [ROOM NUMBER] had an issue with a catheter bag that leaked. However, she stated it was later determined an aide had not properly closed the drainage bag, so in-services were held, and aides were re-educated on catheter care. The DON stated she did not remember a specific reoccurrence with the catheter leaking issue, but if it had reoccurred Environmental Services would have cleaned the carpet. The DON stated she thought the Executive Director was going to have the carpet replaced again. The DON stated the facility was a resident's home, so they tried to ensure it was kept as clean as possible without lingering odors because it was a dignity issue. In an interview on 04/04/2025 at 11:15 AM, the Executive Director stated the resident that previously resided in room [ROOM NUMBER] was very challenging and refused assistance frequently. She stated he often refused to wear briefs and missed the urinal when he tried to use it. She stated she did not recall exactly when the resident received a catheter but recalled instances where the aide had not properly clamped the catheter, and it was a constant challenge. She stated the carpet in room [ROOM NUMBER] was changed about a year ago while the resident was still in the room, and the Environmental Services Director had tried to clean it since then. She stated the carpet might have to be replaced again because no one wanted to live in a house that had an offensive odor. The Executive Director further stated they wanted the facility to be odor free, so they did not make a bad first impression.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to 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 understood. The facility further failed to send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 2 of 2 residents investigated for hospitalizations, Resident (R) 5 and R10. The findings include: Review of the facility's policy/document titled, Transfer/Discharge - Bed Hold Notification Process, undated, revealed a transfer/discharge notice was to be filled out at the time of transfer or discharge and included in the transfer packet that was sent with the resident. Further review revealed the Social Services Director (SSD) would notify the ombudsman as soon as possible, and this could be done via email. Additional review revealed the Business Office Manager (BOM), or designee would contact the resident/family/Power of Attorney (POA) and document the conversation in the Resident Messages portion of the resident's medical record. 1. Review of R5's Face Sheet revealed the facility admitted the resident on 12/18/2024 with diagnoses including dementia and atherosclerotic heart disease. Further review revealed Family (F) 4 was listed as R5's POA. Review of R5's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 12/27/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of one out of 15, indicating the resident was severely cognitively impaired. Review of R5's Hospital Discharge Summary, revealed R5 was hospitalized from [DATE] to 01/14/2025 for right hip pain and anemia. Review of R5's electronic health record (EHR) revealed no documentation that indicated a notice of transfer was provided in writing to the resident or the resident's representative. Review of the facility's document Trilogy-Ombudsman Notification, dated 02/05/2025, revealed the facility notified the ombudsman of R5's transfer. No additional information was provided on the document that indicated information was sent in writing to the ombudsman. 2. Review of R10's Face Sheet, revealed the facility admitted the resident on 02/17/2025 with diagnoses including metabolic encephalopathy and acute kidney failure. Review of R10's MDS, with an ARD of 03/05/2025, revealed the resident had a BIMS score of 15 out of 15, indicating the resident was cognitively intact. Review of R10's Progress Note, dated 02/18/2025, revealed the resident had a sudden onset of uncontrolled muscle movements, and the resident's daughter requested R10 be sent to the hospital for evaluation. Review of R10's Bed Hold Notice, dated 02/18/2025, revealed Family (F) 6 signed the notice, and the (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was transferred to the hospital. In an interview with F6 on 04/03/2025 at 2:57 PM, she stated the facility called to notify her of R10's transfer to the hospital. She further stated she signed and received the bed hold notice when R10 was transferred to the hospital, but transfer paperwork was not provided to her. In an interview with Registered Nurse (RN) 5 on 04/04/2025 at 8:22 AM, she stated when a resident was transferred out of the facility, paperwork was sent with the patient to the receiving provider. RN5 further stated she was still on orientation and had not sent a resident out to the hospital. In an interview with RN4 on 04/04/2025 at 8:25 AM, she stated Continuity of Care Documents (CCD, information given to the provider to allow for a smooth transition of care) were given to Emergency Medical Services (EMS) when they picked up a resident for transfer. She further stated the facility had a transfer form that was filled out, but the form was not typically signed by or provided to the family. Additionally, RN4 stated there was a bed hold form that was signed by the family and/or the resident. In an interview with Licensed Practical Nurse (LPN) 2 on 04/04/2025 at 8:58 AM, she stated when a resident was transferred from the facility, transfer documentation was provided to the ambulance service or other transport person. She further stated nursing provided the bed hold paperwork to the resident/family. LPN2 stated the resident's family or representative was notified verbally of the transfer. In an interview with the Director of Nursing (DON) on 04/04/2025 at 10:14 AM, she stated for resident transfer, printed documents sent with the resident included orders, CCD, and the care plan. She further stated the resident was asked at that time about the bed hold. The DON stated she was not aware of documentation mailed to the resident and the resident's representative. In an interview with the Social Services Director (SSD) on 04/04/2025 at 10:43 AM, she stated she notified the ombudsman via email when a resident was transferred or discharged . The SSD stated she had not sent copies of transfer notifications or bed holds to residents and their families in the two years she had worked at the facility. She further stated those notifications were provided by nursing. In an interview with the Executive Director on 04/04/2025 at 11:15 AM, she stated there was a packet that was used for bed hold and notice of transfer and discharge. She further stated that families were asked about bed holds. The Executive Director stated she was unsure if copies of any of the forms were sent to the resident and their families, and she would have to check on that.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of the facility's document and policies, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 2 nourishment refrigerators, near the 300 Hallway. The findings include: Review of the facility's policy titled, Food Labeling and Dating Policy, dated 04/26/2022, revealed it was the purpose of the policy to provide education and direction on the facility's food labeling and dating guidelines. Further review found it was the facility's policy and procedure to place a printed or handwritten label for any food item brought to the facility. Per the policy, this food product label should have the received on date, production date, and the use by date for the product. The policy stated the label should also have the resident's name and the initial of the staff member that made the label. Observation of the refrigerator for residents' food near the 300 Hallway on 04/03/2025 at 9:55 AM and 10:48 AM revealed two opened tubs of pimento cheese with no resident name but a handwritten date of 03/13/2025. There were also four opened yogurt containers in a bag, 12 unopened supplement shakes, and one opened bottle of an oral rehydration solution that also replaced electrolytes, with only the manufacturers' expiration date. None of those products had resident names, received dates, or initials of staff that placed them in the refrigerator. There were two opened containers of Med Pass supplement, given to residents who needed extra nutrition for wound healing and weight gain, and an opened jar of olives that had received dates, expiration dates, and who received them written on the label, but there was no resident name of to whom they belonged. Additional observation on 04/04/2025 at 9:15 AM of the refrigerator for residents' food near the 300 Hallway revealed the tubs of pimento cheese were removed. There continued to be 12 supplement shakes that were not labeled with a resident's name, a received date, and who received them. There were still two containers of Med Pass supplement and a jar of olives that had received dates, expiration dates, and who received them written on the label, but there was no resident name of to whom they belonged. In an interview with Certified Registered Care Aide (CRCA) 1 on 04/03/2025 at 9:30 AM, she stated when staff placed any food items belonging to a resident provided by their family it should be labeled with the date received, expiration date, staff initials, and resident's name. She stated she was unsure about the yogurt, supplements, olives, and pimento cheese as to whom they belonged. In an interview with Registered Nurse (RN) 1 on 04/03/2025 at 9:51 AM, she stated she was unsure as to whom the yogurt, supplements, olives, and pimento cheese belonged. She stated it was the facility's policy to label foods brought from family for residents with their name and to date them. In an interview with the Assistant Director of Health Services (ADHS) on 04/03/2025 at 10:40 AM, she stated she was unsure as to whom the items in the resident refrigerator belonged. She stated it was important for foods from an outside source to be labeled with a resident's name and the date it was opened to prevent residents from eating spoiled food. She stated it would also prevent a resident from getting another resident's food to which they could be allergic that could cause an adverse reaction from the food if consumed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Director of Health Services (DHS) on 04/04/2025 at 10:35 AM, she stated it was the facility's policy and procedure to place a name and date on any food brought in by a resident's family. She stated it was the duty of dietary to take care of labeling and dating the food. She stated if the food was given to a nursing staff member it was her expectation that they take it to dietary to be labeled and dated. In an interview with the Director of Dietary Services (DDS) on 04/04/2025 at 9:10 PM, he stated he did not put resident foods in the refrigerator. He stated if there were unlabeled foods in the refrigerator, he would print a label that had a received by date, expiration date, and his initials when he did the daily temperature checks. However, he stated it was not his responsibility to place the name of the resident on the food item. In an interview with the Executive Director on 04/03/2025 at 2:17 PM, she stated the facility did not have a policy specifically about food brought by family to the facility but only a general policy about any food received at the facility and how it should be labeled. She stated she did not know that all foods in the residents' refrigerator should have a resident's name on them.

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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 observation, interview, record review, review of the enhanced barrier precaution (EBP) signage from the Centers for Disease Control and Prevention (CDC), and review of the facility's policies, the facility failed to 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 for 2 out of 6 sampled residents, Resident (R) 31 and R36. 1. Licensed Practical Nurse (LPN) 1 with the aid of Nursing Student (NS) 1 was observed pulling up R36 in bed prior to giving her medications. R36 had signage posted on her door that stated she was on Enhanced Barrier Precautions (EBP) for a pressure ulcer. LPN1 and NS1 only had on gloves when pulling up R36 and did not have on a gown. 2. LPN1 was observed dropping a pill on the top of the medication cart and then picking it up with her ungloved hand and placing it in the pill cup with the other pills for R31. Shortly thereafter, LPN1 was observed donning (putting on) gloves prior to giving insulin and not performing hand hygiene prior to donning the gloves. The findings include: Review of the facility's policy titled, Enhanced Barrier Precautions (EBP) Standard Operating Procedure, dated 04/01/2024, revealed the policy was to provide guidance for EBP to decrease the risk of residents becoming colonized and developing infections with multidrug resistant organism (MDRO) status. Further review revealed EBP would be in place during high contact care activities for residents with a chronic wound such as a pressure ulcer. Review of the facility's signage utilized for EBP, undated and labeled as obtained from the CDC revealed: 1) everyone must clean their hands, including before entering and when leaving the room; and 2) providers and staff must also wear gloves and a gown for the following high-contact resident care activities, such as dressing; bathing/showering; transferring; changing linens; providing hygiene; changing briefs or assisting with toileting; device use or care with a central line, urinary catheter, feeding tube, and tracheostomy; or wound care for any skin opening that required a dressing. Review of the facility's policy titled, Specific Medication Administration Procedures, revised 11/2018, revealed the procedure for administering medications in a safe and effective manner. Further review revealed staff should cleanse hands using antimicrobial soap and water or facility approved hand sanitizer before beginning medication administration, before handling medications, and before contact with a resident. Review of the facility's policy titled, Guideline for Handwashing/Hand Hygiene, revised date 02/09/2017, revealed the purpose of the policy was to state that handwashing was the single most important factor in preventing transmission of infections. Further review revealed Health Care Workers should use hand hygiene at times such as: before and after having direct physical contact with residents and after removing gloves, etc. The policy also stated hand hygiene included washing with soap and water and using alcohol-based hand rub, depending on the situation. 1. Review of R36's Face Sheet from her electronic medical record (EMR) revealed the facility admitted the resident on 02/24/20204 with the medical diagnoses of pulmonary fibrosis, stage four pressure (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	ulcer of sacral region, and acute cystitis. Review of R36's Physician Orders from her EMR, dated 02/23/2025, revealed she had an order for staff to use EBP of wearing a gown and gloves during high contact care activities. Review of R36's Nursing Home Comprehensive (NC) Item Set Minimum Data Set [MDS], dated 02/27/2025, revealed R36 was assessed as having a stage three pressure ulcer. Review of R36's Comprehensive Care Plan [CCP], 02/23/2025, revealed R36 required enhanced barrier precautions (EBP) during high contact care related to the presence of a wound. The goal for this care planned focus was the risk for transmission of infection would be minimized with use of EBP. Interventions placed were to don (put on) and doff (remove) and dispose of Personal Protective Equipment (PPE) systematically and appropriately per policy; a face mask should be used as needed. Per the CCP, staff should perform hand hygiene before and after care, per policy; staff should utilize gown and gloves per EBP policy when performing high contact activities of daily living (ADLs) such as dressing, showering/bathing, hygiene, transfers, toileting/changing briefs, and during linen changes; and staff should also utilize gown and gloves per EBP policy during indwelling device care such as central lines, urinary catheters, feeding tubes, and tracheostomies. Observation on 04/03/2025 at 8:34 AM revealed that LPN1 and NS1 entered R36's room to give medications and did not put on PPE as specified for EBP on the signage on R36's door. Further observation revealed LPN1 and NS1 pulled up R36 in bed wearing only gloves and not gowns. In an interview on 04/03/2025 at 8:34 AM with LPN1, she stated the EBP signage posted on R36's door meant that R36 had a wound and that gown, gloves, and mask/face shield should be worn when staff provided wound care but was not needed when routine care, such as pulling up a resident in bed, was performed. In an interview with Certified Registered Medication Aide (CRMA) 5 on 04/03/2025 at 9:35 AM, she stated EBP signage on a resident's door was placed there to let staff know the resident had a wound/pressure ulcer, catheter, ostomy, intravenous catheter (IV), etc. She stated when personal care for the resident was performed, staff should don a gown and gloves and, in some circumstances, wear a mask and/or face shield. In an interview with Certified Registered Care Aide (CRCA) 1 on 04/03/2025 at 9:30 AM, she stated for a resident with EBP precautions, staff did not need to put on a gown when dropping off a meal tray but did when providing direct resident care, such as pulling up a resident in bed, changing a resident, moving a resident, or changing a resident's sheets. In a combined interview with CRCA4 and CRCA6 on 04/03/2025 at 4:55 PM, both stated EBP was used when a resident had a wound, and staff should put on a gown, gloves, and mask/face shield each time they entered the resident's room. In an interview with CRMA3 on 04/03/2025 at 4:59 PM, she stated she did not don a gown for giving medications to a resident on EBP. In an interview with Registered Nurse (RN) 1 on 04/03/2025 at 9:51 AM, she stated EBP signage on a resident's door indicated she should wear a gown and gloves when performing wound care or perineal care for a resident with a catheter. She stated when routine care such as pulling up a resident in (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185482	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that resident. She stated it was not acceptable to pick up the pill with ungloved hands and administer the pill. The ADON stated it was her expectation that during medication administration staff should wear gloves. In an interview with the Infection Prevention Nurse (IPN) who was also the Director of Nursing (DON) on 04/03/2025 at 10:40 AM, she stated EBP education was done with all staff in an online format and in person at in-services. She stated at the in-service training sessions she went over Standard Precautions, EBP, and the types of Contact Precautions along with the PPE needed when giving care. The IPN/DON stated she observed and talked with staff weekly to assess for understanding and compliance with PPE for Standard, EBP, and Contact Precautions. The IPN/DON stated staff had annual check offs for donning and doffing of PPE competencies where staff performed a return demonstration of the education. The IPN/DON stated it was her expectation when staff saw the EBP signage on a resident's door, they don the PPE outlined on the signage (gown, gloves, mask) when performing care with direct contact with the resident: bathing/showering, changing the resident, incontinence care, etc. She stated nurses should always put on a gown and gloves when entering a resident's room to give medication for a resident that was on EBP, because residents might need other care that was direct contact care. She stated pulling up a resident in bed was considered direct resident care, and staff should have worn a gown and gloves when doing so. The IPN/DON stated hand hygiene should be performed before and after care, and staff should also do hand hygiene prior to putting on gloves or changing gloves. The IPN/DON stated pills dropped on the medication cart should be discarded and should never be touched with ungloved hands. In an interview on 04/03/2025 at 6:03 PM with the Executive Director and Administrator, both stated staff should follow the signage posted on a resident's door and the facility's policy for residents who had EBP signage posted on their room door. Both stated staff only needed to put on a gown and gloves when providing direct resident care, and if a staff member stepped in a room to answer a call light or give a resident some butter, they did not need to put on PPE. However, they stated, if a staff member was pulling up a resident in bed prior to giving medications, the staff member should be wearing a gown and gloves; and hand hygiene should always be performed before touching a resident, before putting on PPE, and after resident care. They both stated, if a staff member dropped a pill onto the top of the medication cart, that staff member would need to dispose of the pill and get a new pill.