STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235257	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iron County Medical Care Facility	1523 U.S. Highway 2 Crystal Falls, MI 49920

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** All times recorded in Eastern Daylight Time (EDT), unless otherwise noted. Based on observation, interview and record review, the facility failed to 1. Ensure oxygen was administered per physician order and; 2. Ensure maintenance of oxygen and nebulizer equipment in a sanitary manner, for one Resident (#65) of one resident reviewed for oxygen administration. Findings include: Resident #65 (R65) Review of the Minimum Data Set (MDS) assessment, dated 2/2/2025, revealed R65 was admitted to the facility on [DATE] and had diagnoses including Chronic Obstructive Pulmonary Disease (COPD), anxiety and dementia. Further review of the MDS revealed R65 scored 10 out of 15 on the Brief Interview for mental Status (BIMS), indicating the Resident had moderate cognitive impairment. On 4/15/2025 at 2:38 p.m., R65 was observed sleeping in bed and was receiving supplemental oxygen via nasal cannula from a portable oxygen concentrator with a flow rate of three liters per minute (3 L/min). A tag attached to the oxygen tubing was dated 3/13/2025. On 4/16/25 at 1:15 p.m., R65 was observed sleeping in bed and was receiving supplemental oxygen via nasal cannula from a portable oxygen concentrator with a flow rate of 3 L/min. The tag attached to the oxygen tubing remained dated 3/13/2025. Review of R65's Electronic Medical Record (EMR) revealed an active physician order, dated 9/4/2025 at 11:30 a.m. [Central Savings Time] for O2 [oxygen] @ [at] 2 LITERS [per minute] AS NEEDED - Does not want humidified water. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R65's EMR, including progress notes, assessments, and the April 2025 Medication and Treatment Administration Records (MAR's and TAR's) revealed no indication for the increased rate of oxygen administration observed above in the physician's order section. The most recent oxygen order was dated 9/4/2024 and directed staff to provide a flow rate of 2 L/min as needed. Review of R65's most recent vital signs, dated 4/15/2025 at 8:53 a.m. (Central Daylight Time), revealed R65 was assessed as having an oxygen saturation level of 97% on room air. R65's April 2025 MAR and TAR revealed no documentation indicating R65 was receiving supplemental oxygen. During an interview on 4/17/2025 at 9:05 a.m., the Director of Nursing (DON) reported oxygen was to be administered per physician order and if a greater need is identified, nursing staff should conduct and document an assessment indicating the change in condition requiring administration of a higher rate of oxygen than what was ordered. The DON reported staff should also notify the physician and document the notification, along with any new orders, in the EMR. On 4/17/2025 at 9:20 a.m., R65 was observed lying in bed, awake, receiving supplemental oxygen via nasal cannula from a portable oxygen concentrator set to deliver 3 L/min. The tubing was again observed to be dated 3/13/2025. Further observation revealed a nebulizer atop R65's nightstand with tubing attached leading from the machine with the medication chamber and mouthpiece lying directly on the nightstand without a protective barrier between the equipment and the top of the nightstand. It was noted during the observation an illegible date was written in black marker on the side of the medication chamber. At the time of the observation R65 reported she was feeling shorter of breath lately and was unaware of what concentration of oxygen she was receiving from the concentrator. R65 reported her most recent nebulizer treatment was administered the previous day, on 4/16/2025. During an interview on 4/17/2025 at 9:25 a.m., Licensed Practical Nurse (LPN) G stated, if a resident required an increase in supplemental oxygen above what was ordered, nursing should document the change in condition in a progress note and notify the physician to report changes and obtain a new order for the higher rate. LPN G reviewed R65's EMR and stated the active order was for supplemental oxygen at 2 L/min as needed. LPN G reported he could not find an assessment documented in the EMR warranting the increase of R65's supplemental oxygen from 2 L/min to 3 L/min. During an observation of R65 immediately following the interview, LPN G confirmed R65 was being administered oxygen at 3 L/min and stated, I have no idea why. LPN G was asked about the date on the oxygen tubing. LPN G confirmed the tubing dated 3/13/25 was out of date and reported facility protocol was to change the tubing weekly. LPN G was alerted to the nebulizer tubing with medicine chamber and mouthpiece portions resting directly on the top of the nightstand. LPN G detached the tubing and reported the equipment should have been cleaned and stored in a plastic bag. During an interview on 4/17/2025 at 11:15 a.m., facility Infection Preventionist (IP) I reported the facility protocol was for oxygen tubing to be replaced and appropriately dated every two weeks. IP I was queried about the maintenance of nebulizer equipment and reported nursing staff were responsible to ensure appropriate care and storage of the administration sets. IP I reported the tubing, medication chamber and mouthpiece should be disassembled after each use, cleansed and dried, then stored in a plastic bag. IP I provided the facility policy at the time of the interview. Review of the facility policy titled, Cleaning & Disinfecting Nebulizers, effective date 2025, revealed the following: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After each aerosol treatment, remove the cup. Mask or mouthpiece and wash with warm water and mild dish detergent. Thoroughly rinse the parts to remove all soap and residue. Allow the parts to air dry on a clean surface using a paper/cloth barrier between them. Review of the facility policy, titled, Oxygen Use and Set-Up, provided by the DON with an effective date of 3/18/2020, revealed the following: The physician standing order for oxygen is only for emergency purposes for 24 hours. If oxygen is started, notify the physician and obtain an order for oxygen to include liter flow/min, frequency of oxygen an oxygen saturation checks and conserving devices if used. O2 tubing on concentrator and companions on wheelchairs will be changed every 2 weeks and prn [as needed] . The nurse is responsible for beginning oxygen therapy per MD [physician] orders: turning on O2 companions, setting flow rate, checking to ensure there is proper flow from the nasal cannula and checking oxygen saturations each shift for any resident receiving oxygen therapy.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** All times are noted in Eastern Daylight Time unless otherwise noted Based on interview and record review, the facility failed to ensure that Medication Regimen Reviews (MRR) were reviewed, addressed by the Physician, and maintained in the clinical record for four Residents (#67, #36, #65, and #90) of five residents reviewed for MRR, resulting in the potential for the administration of unnecessary medications and adverse medication side effects. Findings include: Resident #67 (R67) Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed R67 was admitted to the facility on [DATE] with active diagnoses that included: dementia, anxiety disorder, depression, psychotic disorder, and diabetes mellitus. R67 scored a 7 of 15 on the Brief Interview for Mental Status (BIMS) assessment reflective of severe cognitive impairment. Review of R67's Electronic Medical Record (EMR) revealed no pharmacy reports were available for 10/21/24, 11/27/24, 12/26/24, 2/17/25, and 3/21/25. During an interview on 4/16/25 at 11:42 a.m., the Director of Nursing (DON) stated, I do not know where the pharmacy reports are . I should keep them, but I don't. The DON examined the EMR and acknowledged that she was unable to find the pharmacy reports. During an interview on 4/17/25 at 9:37 a.m., the DON acknowledged that there was no way to review what the pharmacist recommended, if the Medical Director (MD) or Nurse Practitioner (NP) agreed/disagreed with the recommendations, or if the MD or NP gave a reason for their decision. During and interview on 4/17/25 at 10:45 a.m., the Nursing Home Administrator (NHA) acknowledged there was no one at the facility ensuring the pharmacy consults were being addressed and stated, I know the system is broken and we are deficient. Resident #36 (R36) Review of the MDS assessment, dated 3/23/2025, revealed R36 was admitted to facility on 6/8/2017 and had diagnoses including dementia, diabetes, post-traumatic stress disorder (PTSD) and stroke. Review of R36's EMR revealed no pharmacy reports were available for 11/25/2024 and 12/20/2024. On 4/16/024 at 12:50 p.m., the DON reported all available pharmacy recommendations had been provided. Review of the pharmacy recommendations provided by the DON revealed no reports for R36 for the dates requested. Resident #65 (R65) (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS assessment, dated 2/2/2025, revealed R65 was admitted to the facility on [DATE] and had diagnoses including Chronic Obstructive Pulmonary Disease (COPD), anxiety, hypertension, diabetes and dementia. Review of R36's EMR revealed no pharmacy reports were available for 1/27/2025. On 4/17/2025 at 9:02 a.m., the DON reported all pharmacy recommendations had been provided. The DON was alerted to the missing recommendations for R36 and R65. Another request was made for the missing recommendations for R36 and R65. The reports were not received by the end of the survey on 4/17/2025 at 2:00 p.m. Resident #90 (R90) Review of R90's admission Record revealed admission to the facility on 2/9/24, with current active diagnoses that included: fracture of the left femur, mild cognitive impairment, urinary tract infection and vitamin D deficiency. Review of R90's EMR revealed no pharmacy reports were available for 10/14/2024 and 12/26/2024. On 4/17/25 at 10:45 a.m., the DON confirmed all available pharmacy recommendations had been provided, and acknowledged no Medication Regimen Review reports were available for the above dates for R90. Review of the Medication Regimen Review policy, effective date: 9/11/24, revealed the following, in part: Medication Regimen Review (MRR) or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication . D. The pharmacist shall document, either manually or electronically, that each medication regimen review has been completed. a. The pharmacist shall document either that no irregularity was identified or the nature of any identified irregularities . F. Written communications from the pharmacist shall become a permanent part of the resident's medical record .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to prevent duplicate drug therapy of Vitamin D for one Resident (#90) of five residents reviewed for unnecessary medications. This deficient practiced resulted in an excessive dose of D3 and the potential for Vitamin D toxicity. All times noted are Eastern Daylight Savings Times (EDST) unless otherwise noted. Findings include: Resident #90 (R90) Review of R90's admission Record revealed admission to the facility on 2/9/24, with current active diagnoses that included: fracture of the left femur, mild cognitive impairment, urinary tract infection and vitamin D deficiency. Review of available Medication Regimen Review (MRR) reports for R90 revealed the following, in part: 1. Consultation Report Date 5/30/24, Comment: [R90] receives ergocalciferol (vitamin D2) 50,000 units weekly on Thursdays. vitamin D3 is more efficiently absorbed and utilized by the body and may be better at increasing and maintaining vitamin D in the body. Recommendation: Please consider changing from ergocalciferol (vitamin D2) to vitamin D3 50,000 units weekly on Thursdays . Physician Response: I accept the recommendation(s) above, please implement as written. Signed by R90's Physician on 6/3/24. 2. Consultation Report Date 6/28/24. Comment: [R90's] prescriber accepted a pharmacy recommendation to change vitamin D2 to vitamin D3 on 6/3/24. This medication change occurred however the vitamin D2 did not get discontinued. Recommendation: Please discontinue vitamin D2 per pharmacy recommendation. Review of R90's June 2024 Medication Administration Record (MAR) revealed ergocalciferol (vitamin D2) 1. 25 MG (milligrams) (50,000 units) continued to be administered on 6/6, 6/13, 6/20, and 6/27/24 per a physician order with a Start Date of 4/4/24, and a discontinue date of 7/3/24. An additional physician order for Cholecalciferol (vitamin D3) (50,000 units), with a Start Date of 6/5/24, was administered to R90 on 6/5, 6/12, 6/19, and 6/26/24 resulting in duplicative administration of vitamin D weekly (100,000 units total) to R90 during the month of June 2024. During an interview on 4/17/25 at 10:56 a.m., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) N were asked about R90's May and June pharmacy Consultation Reports. The DON and ADON N reviewed R90's physician orders, pharmacy recommendations and MAR documentation. Both confirmed R90 received duplicative administration of vitamin D throughout June 2024. The DON acknowledged she was unaware this duplication had occurred. The DON stated, The audit side of this (medication regimen review) is what I was not seeing because of the (different) electronic process. There is a process for double-checking (physician orders) but I believe this was just missed. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Regimen Review policy, effective date 9/11/24, revealed the following, in part: Medication Regimen Review (MRR) or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes: I. Review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a medication error rate less than 5% in four Residents (#95, #8, #70, & #23) of 12 residents reviewed for medication administration. This deficient practice resulted in a medication administration error rate of 13.33%, based on 4 medication errors in 30 opportunities for error. Findings include: Resident #95 (R95) R95 was admitted to the facility on [DATE] with diagnoses of dementia, Down Syndrome, hypokalemia (low potassium level), and others. R95 had a physician's order dated 4/15/25 to administer three 10 mEq (milliequivalent) Potassium Chloride ER (extended release) capsules. The order contained the instruction: Do not crush. On 4/16/25 at 12:50 PM, Registered Nurse (RN) K was observed preparing and administering medications on the 800-unit, Lilac Lane. When preparing medications for R95, RN K opened the capsules of potassium and crushed the content of the capsules before placing the crushed content in pudding. RN K was asked why the potassium medication for R95 was crushed. RN K said she was a charge nurse and did not usually administer medications, so she had another nurse prepare a list of residents who required medication to be crushed. RN K produced a sheet of paper listing residents' names. Next to R95's name was written crush. R95's physician's orders and care plan were reviewed on 4/16/25. R95 did not have a physician's order to crush medications. The care plan did not indicate medications were to be crushed. Resident #8 (R8) R8 was admitted to the facility on [DATE] with diagnoses including but not limited to hypokalemia. R8 had a physician's order dated 1/21/25 to administer two 10 mEq capsules of potassium chloride ER three times a day related to hypokalemia. The order instructions included: Do not crush. During medication administration on 4/16/25 at 12:50 PM, RN K opened the potassium ER capsules and crushed the content before placing the content in applesauce to administer to R8. After administering the medication in applesauce, RN K assisted R8 to take a sip of water from a cup. R8's physician's orders and care plan were reviewed on 4/16/25. R8 did not have a physician's order to crush medications. The care plan did not indicate medications were to be crushed. Resident #70 (R70) R70 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease and hypokalemia. R70 had a physician's order dated 1/21/25 to administer two potassium chloride 10 mEq capsules three times per day for hypokalemia. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During medication administration to R70 in their room on 4/16/25 at 1:31 PM, LPN L placed one capsule of potassium chloride in R70's mouth. The potassium chloride capsules were blue in color. R70 began chewing the capsule. R70 chewed the potassium capsule continuously until their mouth and lips turned blue from the blue capsules. LPN L attempted to give R70 the second capsule while R70 was still chewing the first capsule. R70 shook her head no. LPN L exited the room and returned to the medication cart outside the room. LPN L labeled the medication cup with R70's name and placed it in the top drawer of the medication cart atop the cup containing R93's baclofen. LPN L was told R70 was still chewing the first potassium capsule. LPN L re-entered R70's room and stayed until R70 was finally able to swallow the capsule. LPN L did not offer water to R70 after the capsule was swallowed. Nurse progress notes and medication notes were reviewed on 4/17/25 at 9:04 AM. LPN L did not document the difficulty R70 had with swallowing the potassium capsules, nor was there any documentation indicating R70's physician was notified the resident did not receive the prescribed dose of medication or requesting to change the medication to liquid form. Resident #23 (R23) R23 was admitted to the facility on [DATE] with diagnoses that included constipation. R23 had a physician's order dated 1/21/25 for Senna (laxative) Oral Syrup one teaspoon (tsp) twice daily for constipation. During medication administration on 4/17/25 at 7:50 AM, LPN M removed the bottle of senna from the medication cart before removing the cap from the bottle and pouring one tsp of medication from the bottle into a medication cup. LPN M did not shake the bottle of medication prior to pouring it into the medication cup to ensure the medication was dispersed throughout the liquid for uniform distribution of the active ingredient. LPN M crushed R23's other medications and placed all medications, including the unshaken liquid senna into a cup of coffee. LPN M provided R23 the cup of coffee containing the medications. R23's physician's orders and care plan were reviewed on 4/16/25. R23 did not have a physician's order to crush medications or to administer medications in coffee. The care plan did not indicate medications were to be crushed or placed in coffee. The Director of Nursing (DON) was interviewed on 4/17/25 at 11:31 AM. The DON said the beads in potassium capsules should not be crushed. The DON said physicians' orders are required to crush, open or modify medication forms of delivery. When asked the expectation for disposition of medication if a nurse prepares a medication and a resident either refuses or is not available to administer medications, the DON said the medications were expected to be destroyed in a drug buster solution. The DON confirmed medication cups containing medications should not be labeled and stored in medication carts. The DON said nurses should be washing their hands during medication administration between residents. The DON said medications that fall on the medication cart during preparation should be disposed of in drug buster solution. The DON confirmed liquid medication should be shaken prior to pouring the medication. The DON conveyed the expectation of physician notification if a resident does not take medications as prescribed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the United States Food and Drug Administration (FDA), the prescribing information for potassium chloride extended-release capsules include the following, in part: . Administration and Monitoring . Take with meals and with a full glass of water or other liquid . should be swallowed immediately without chewing and followed with a glass of water or juice to ensure complete swallowing of the microcapsules . (www.accessdata.fda.gov/drugsatfda_docs/label/2018/018238s046lbl.pdf). The facility policy titled Medication Administration dated as effective 10/7/21 documented, in part: . Medications will be administered per MD orders . Perform hand hygiene prior to administering medication . Shake well to mix suspensions. 17. Crush medications as ordered. Do not crush medications with do not crush instructions. 18. Observe resident consumption of medication. 19. Perform hand hygiene after medication administration . If resident refuses medications, document in EHR (Electronic Health Record) and notify Charge Nurse. If medication has been prepared and it is then refused, destroy in Drug Buster . 24. Report and document any adverse side effects or refusals . Crushed medications require a Physician order to crush, and this must also be added to that specific medication on the EMAR [Electronic Medication Administration Record] .

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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 - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure hand hygiene was performed during fresh water pass and catheter care, for 7 Residents (R11, R32, R33, R38, R50, R52 and R55), out of 22 sample residents reviewed for hand hygiene. This deficient practice resulted in the potential for cross-contamination of infectious organisms between residents in the facility. All times noted are Eastern Daylight Savings Time (EDST) unless otherwise noted. Findings include: During an observation of fresh water pass on 4/15/25 at 2:08 p.m. , Certified Nurse Aide (CNA) A was observed delivering fresh water mugs and removing the previously used water mugs from resident rooms. CNA A delivered fresh water and removed previously used water mugs from R11's, R32's, R33's, R52's, R50's, and R38's rooms, without the performance of hand hygiene between rooms. During an interview on 4/15/25 at approximately 2:30 p.m., when asked if they had performed hand hygiene between rooms while passing fresh water and removing used water mugs from resident rooms, CNA A stated, No, I did not do any hand hygiene between the rooms. I should probably grab hand sanitizer for my pocket. We have one (hand sanitizer bottle) at the nurses' station. CNA A acknowledged understanding of the importance of hand hygiene between touching each residents clean and dirty water mugs. R55 During R55's catheter care observation on 4/16/25 at 2:04 p.m., CNA O and CNA C both donned Enhanced Barrier Precautions (EBP) which included gloves. CNA O performed the care, while CNA O was assist with positioning of R55. CNA O used a clean, wet cloth to cleanse R55's catheter tubing and genitals. CNA O realized a clean incontinence brief was required and left R55's bedside with the dirty gloves used to cleanse R55's genitals still on their hands. CNA O opened the Resident's closet doors by grabbing the handles with their contaminated gloves, retrieved a clean incontinence brief, and closed the closet door. R55's brief was changed with CNA O still wearing the contaminated gloves. CNA O and CNA C both assisted R55 with his clothing and application of protective boots to both feet. CNA O remained in contaminated gloves touching clothing, the protective boots and environmental surfaces. During an interview on 4/16/25 at 2:17 p.m., CNA O was asked to explain the purpose of Enhanced Barrier Precautions. CNA O stated, It is to protect him from UTIs (urinary tract infections). CNA O agreed they did touch the cabinet handles, protective booties and resident clothing with their dirty gloves and acknowledged they should have performed hand hygiene and donned clean gloves after cleaning R55's genitals and catheter tubing. During an interview on 4/16/25 at 2:20 p.m., Registered Nurse (RN) B was asked when hand hygiene and donning of clean gloves should be performed during catheter care. RN B said gloves should be removed when dirty and hand hygiene performed before touching other environmental surfaces. RN B acknowledged the risk for cross-contamination between residents and staff when environmental surfaces were contaminated by the CNA O's dirty gloves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iron County Medical Care Facility	1523 U.S. Highway 2 Crystal Falls, MI 49920

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 - Some	Review of the Hand Hygiene policy, effective date 2025, revealed the following, in part: . All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility . The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . During an interview on 4/17/25 at 11:00 p.m., the above observations were discussed with the Director of Nursing (DON). The DON expressed understanding of the deficiency concern related to the failure to perform hand hygiene and the potential for cross-contamination of infectious organisms within the facility.