| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 12/24/2025 |
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| F0000 | INITIAL COMMENTS<br><br>A Desk Review Revisit Survey was initiated and concluded on 12/24/2025. It was determined the facility had achieved substantial compliance on 12/19/2025 as alleged. | F0000 | | |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F0000 | INITIAL COMMENTS<br><br>A Recertification and Complaint survey concluded on 12/03/2025. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.<br><br>No deficiencies were issued related to 695693, 695694, 695696, 695697, 695698, 695699, 695700, 695701, and 695703.<br><br>Survey Dates: 09/16/2025 – 12/03/2025<br><br>Survey Census: 46<br><br>Sample Size: 20<br><br>Supplemental Residents: 26 | F0000 | | 12/19/2025 |
| F0644<br>SS = D | Coordination of PASARR and Assessments<br><br>CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br><br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review, the facility | F0644 | 1. The MDS Coordinator completed a Significant Change referral in the KLOCS system on 10/22/25 for Resident 5 based on diagnoses Resident 5 was given during hospital psychiatric stay and readmission to facility on 11/25/24. Resident 5 did not qualify for Level II evaluation and was approved for Level of Care on 12/4/25 in the KLOCS system.<br><br>2. On 10/22/25, all residents were reviewed by the MDS Coordinator and Social Services Director to determine if any current residents have a qualifying diagnosis of mental illness, intellectual disability or deficit in intellectual functioning that were not captured correctly by the PASRR process and none of the aforementioned diagnoses were identified for any current residents. No additional concerns were identified regarding the PASRR Level II referrals.<br><br>3. a. On 10/29/25, Home Office Social Service Support provided re-education to the ED, DHS, ADHS, MDS, SSD and Admissions Team regarding the PASRR process including the process required to refer for Level II review.<br><br>b. To ensure a system is in place to review all new mental health diagnoses, the SSD will now begin reviewing the notes from the psychiatric provider during the Clinically At Risk meeting to ensure Level | 12/19/2025 |

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

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| F0644 SS = D | Continued from page 1<br>failed to refer residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for Level II Pre-admission screening and resident review (PASRR) evaluation for 1 of 1 sampled resident (Resident (R) 5).<br><br>The findings include:<br><br>The facility did not provide a policy specific to PASRR evaluation.<br><br>Review of Resident (R) 5's, "Face Sheet" revealed the facility originally admitted the resident on 07/01/2022 with the most recent re-admission date of 11/25/2024 with diagnoses including acute and chronic respiratory failure, bipolar disorder, dementia, major depressive disorder, generalized anxiety disorder, and paranoid personality disorder.<br><br>Review of R5's, "Pre-admission Screening and Resident Review (PASRR)," dated 07/01/2022 revealed diagnoses of major depressive disorder, generalized anxiety disorder, and dementia. Further review revealed a Level II referral was not indicated at that time.<br><br>Review of R5's "Comprehensive Care Plan (CCP)" revised 08/05/2025 revealed the resident demonstrated altered behaviors including delusions and received medication for bipolar disorder.<br><br>Review of R5's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/18/2025 revealed the facility assessed the resident with a "Brief Interview for Mental Status (BIMS)" exam score of 15 out of 15, indicating the resident was cognitively intact. Further review revealed bipolar disorder was coded as an active diagnosis.<br><br>Review R5's "Resident Progress Notes," dated 11/14/2024 revealed the resident was sent out of the facility to an outside hospital for psychiatric evaluation.<br><br>Review of R5's hospital discharge summary dated 11/25/2024 revealed the resident was hospitalized for bipolar disorder with recent mania and psychosis. | F0644 | Continued from page 1<br>II referrals are not missed.<br><br>c. The Interdisciplinary Team will continue to review new admission diagnoses during daily Clinical Care Management meeting to ensure any resident admitted with the qualifying diagnosis of mental illness, intellectual disability or deficit in intellectual functioning are referred for Level II assessment as indicated.<br><br>4. a. An Ad Hoc Quality Assurance meeting was held on 9/29/25 with the Medical Director and the facility QAPI Committee to review the plan of correction and ensure the implementation of the plan.<br><br>b. Starting on 12/22/25, the Executive Director will conduct audits a minimum of 5 residents weekly for 4 weeks, 5 residents every other week for 4 weeks, then 5 residents for 1 month to ensure residents are referred for Level II assessment if indicated.<br><br>c. Starting on 12/26/25, a Quality Assurance meeting will be held weekly for 4 weeks, then monthly for recommendations and further follow up regarding the above stated plan<br><br>d. The QA Committee will determine at what frequency any ongoing audits will need to continue. The Executive Director has the oversight to ensure an effective plan is in place to meet the residents' wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction. | |

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| F0644 SS = D | Continued from page 2<br><br>Review of R5's "Resident Progress Notes," dated 11/25/2024 revealed the resident returned to the facility with diagnoses of bipolar 1, psychosis, and paranoia.<br><br>Surveyor attempts to interview R5 on 09/16/2025 at 2:11 PM were unsuccessful as R5 refused interview.<br><br>During an interview with the Social Services Director (SSD) on 09/19/2025 at 9:41 AM, she stated the Admissions Department was responsible for initial PASRR screenings. She stated she helped some but did not have access to the Kentucky Level of Care System (KLOCS). The SSD further stated if a resident developed a new diagnosis after the initial screen, the Minimum Data Set (MDS) Coordinator submitted that information to KLOCS.<br><br>During an interview with the MDS Coordinator on 09/19/2025 at 9:49 AM, she stated if a resident had a new qualifying diagnosis after the Level I PASRR was completed, the diagnoses was submitted through the KLOCS system. She further stated the system determined if Level II services were needed. The State Survey Agency (SSA) Surveyor observed the MDS Coordinator as she accessed the KLOCS system; however, there were no new diagnoses listed for R5. The MDS Coordinator stated R5's new diagnoses should have been submitted. Additionally, she stated it was important new diagnoses were submitted to KLOCS so the facility provided newly identified care and services to the resident.<br><br>During a follow up interview with the MDS Coordinator on 09/19/2025 at 12:16 PM, she stated she contacted and spoke to someone at KLOCS and found R5's new diagnoses information was not submitted as required.<br><br>During an interview with the Director of Health Services (DHS) on 09/19/2025 at 1:34 PM, she stated R5 should have been referred for a Level II evaluation when the resident received new qualifying diagnoses. The DHS stated it was important referrals were made when indicated because the resident may need services the facility was not equipped to provide.<br><br>During an interview with the Executive Director on 09/19/2025 at 1:46 PM, she stated the facility did not have a specific policy related to PASRR screenings, but rather the facility followed the Centers for Medicare | F0644 | | |

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| F0644 SS = D | Continued from page 3<br>and Medicaid Services (CMS) and the State guidelines for PASRR screenings. She stated it was her expectation the facility followed those guidelines so residents received appropriate care and services. | F0644 | | |
| F0760 SS = D | Residents are Free of Significant Med Errors<br><br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br><br>§483.45(f)(2) Residents are free of any significant medication errors.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents were free of any significant medication errors and that medications were received at the right time for 1 of 8 sampled residents (Resident (R) 6).<br><br>The findings include:<br><br>Review of the facility policy titled, "Medication Administration Times Procedural Guidelines," revised 12/01/2021 and reviewed 12/17/2024 revealed guidelines for determination of medication administration times based on a resident's preference unless a specific time is designated by the attending physician.<br><br>Review of the facility policy titled, "Specific Medication Administration Procedures/Injectable Medication Administration," revised 11/2018 revealed the procedure included guidelines to check the five rights (right patient, right drug, right route, right dose, right time) when medication selected, as dose is prepared, after dose prepared, before medication is put away, and before injection is administered.<br><br>Review of Resident (R) 6's, "Face Sheet" revealed the facility admitted the resident on 02/20/2025 with diagnoses including type II diabetes and congestive heart failure (CHF).<br><br>Review of R6's "Comprehensive Care Plan (CCP)" dated 02/21/2025 revealed a risk for hypoglycemia/hyperglycemia (low/high blood glucose) related to a diagnosis of diabetes mellitus. | F0760 | 1.a. Resident 6 did not suffer any adverse effects from the above-mentioned deficient practice.<br><br>b. The Director of Health Services notified Resident 6 and her physician about the insulin administration incident that occurred on 9/17/2025; no new orders were given.<br><br>c. The Director of Health Services provided re-education to RN 2 pertaining to insulin administration during the scheduled time on 9/22/25.<br><br>2. a. All residents have the potential to be affected by the deficient practice.<br><br>b. The Director of Health Services completed an audit on 9/22/25 to review any insulin administration that was documented as administered outside of ordered time and any findings of noncompliance with following the physician's order when administering insulin resulted in immediate 1:1 re-education in addition to a teachable moment with any staff identified from audit.<br><br>3. a. The Clinical Support Nurse provided re-education to the Director of Health Services, Asst Director and Infection Control Nurse regarding Trilogy's policy and procedures regarding medication administration, medication errors, and insulin administration that was completed on 9/22/25.<br><br>b. Once trained, the DHS, ADHS, and IC Nurse provided re-education to all the Nurses and CMT's regarding Trilogy's policy and procedures regarding medication administration, medication errors, and insulin administration that was initiated on 9/22/2025 and completed on 10/22/2025. Staff were also required to complete a posttest related to this training and achieve a 100% passing score to demonstrate understanding.<br><br>c. After 10/22/25, any newly hired Nurses and CMTs were and will be educated by the Director of Health Services | 12/19/2025 |

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| F0760 SS = D | Continued from page 4<br><br>Review of R6's blood glucose readings for 09/17/2025 revealed the following: 123 at 9:37 AM, 255 at 10:27 AM, and 124 at 4:17 PM.<br><br>Review of R6's orders revealed insulin lispro was ordered for administration before meals at 6:30 AM - 9:00 AM, 10:00 AM - 12:30 PM, and 3:30 PM - 6:30 PM.<br><br>Review of R6's electronic Medication Administration Record (eMAR) revealed Registered Nurse (RN) 2 documented administration of 6 units lispro insulin to R6 on 09/17/2025 at the 10:00 AM – 12:30 PM timeframe.<br><br>Observation on 09/17/2025 at 2:27 PM revealed RN2 entered R6's room and administered 6 units of lispro insulin via subcutaneous route.<br><br>During an interview with RN2 on 09/17/2025 at 3:55 PM when asked about the administration time of R6's insulin, he stated that was when he got to her to administer the insulin. The State Survey Agency (SSA) Surveyor asked RN2 if he saw a concern with giving insulin when the resident's blood glucose was checked at 10:27 AM and after she had finished her lunch, he stated R6 was typically stable with her blood glucose readings, but if it had been low, he would have addressed it earlier.<br><br>During an interview with Certified Resident Care Associate (CRCA) 1on 09/19/2025 at 7:53 AM revealed she was also a Certified Residential Medication Aide (CRMA). She stated she checked residents' blood glucose levels typically around 11:00 AM for the lunch meal, and any needed insulin was administered before they ate.<br><br>During an interview with Licensed Practical Nurse (LPN) 4 on 09/19/2025 at 12:45 PM, she stated before she administered insulin to a resident, she verified the order, and the amount of insulin needed based on the resident's glucose check reading. She stated insulin was important insulin to be administered at the right time because if too much time passed after their glucose check, their sugar could have either increased or dropped.<br><br>During an interview with LPN1 on 09/19/2025 at 1:05 PM, she stated she used the five rights when she administered medications and that included insulin. She | F0760 | Continued from page 4<br>or Assistant Director of Health Services regarding medication administration, medication errors, and insulin administration with a post-test completed to ensure staff knowledge of the education provided was retained.<br><br>d. Beginning 12/22/25, an audit will be conducted by the DHS or designee on the administration of insulin within scheduled time. Th DHS or designee will review administration times of insulin on all residents who receive insulin daily 5 times per week for 4 weeks, 3 times per week for 1 month, and 1 time per week for 1 month.<br><br>4. a. An Ad Hoc Qual ty Assurance meeting was held on 9/29/25 with the Medical Director and the facility QAPI Committee to review the plan of correction and ensure the implementation of the plan.<br><br>b. Starting on 12/26/25, a Quality Assurance meeting will be held weekly for 4 weeks, then monthly for recommendations and further follow up regarding the above stated plan<br><br>c. The QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet the residents' wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction. | |

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| F0760 SS = D | Continued from page 5<br>stated it was important insulin was given at the right time because if a resident experienced a change in their blood glucose level, they possibly received the wrong dose of insulin.<br><br>During an interview with the Director of Health Services (DHS) on 09/19/2025 at 1:34 PM, she stated it was her expectation staff followed the facility's medication administration policies. She further stated she expected staff adhered to the five rights of medication administration. The DHS stated it was important insulin was administered at the right time based on blood glucose readings, so the resident did not have either an increase or drop in their blood glucose. The DHS stated if too much time passed before insulin was administered, a resident's blood glucose was potentially two to three times higher than the initial reading.<br><br>During an interview with the Executive Director on 09/19/2025 at 1:46 PM, she stated it was her expectation staff administered medications at the right time as ordered by the physician, so that the facility provided the appropriate care and services each resident needed. | F0760 | | |
| F0812 SS = F | Food Procurement,Store/Prepare/Serve-Sanitary<br><br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br><br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve | F0812 | 1. The Director of Food Services reviewed the hair covering requirement per Trilogy policy and Federal Food Code with the Cook during the survey period and all additional employees in the Dining Services Department.<br><br>2. a. All residents have the potential to be affected if hair coverings are not worn according to policy and food code, therefore on 9/30/25 the Executive Director educated the Director of Food Services on these requirements.<br><br>b. On 10/28/25 – 11/1/25 the DFS then re-educated all of the Dining Services employees on the policy for wearing hairnets and hair coverings and demonstrated proper hairnet/hair covering application.<br><br>c. After 11/1/25, newly hired employees in the Dining Services Department were educated on uniform expectations during Onboarding and the Director of Food Services will in-service each new employee on the hairnet/hair covering requirement.<br><br>3. The DFS has now incorporated into the Dining | 12/19/2025 |

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| F0812 SS = F | Continued from page 6<br>food in accordance with professional standards for food service safety.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview and review of facility policy, the facility failed to prepare, store, and serve food under sanitary conditions for 51 of 52 residents who received food from the kitchen.<br><br>The findings include:<br><br>Review of the facility's "Hair Restraint Policy' revised date 07/09/2025, revealed all dining service employees were required to wear hair restraints as required by the Federal Food Code, Hair Restraints 2-402.11. Review of the Federal Food Code dated 2009, revealed food employees shall wear hair restraints such as hats, hair covering or nets that are designed and worn to effectively keep their hair from contacting exposed food.<br><br>Observation, on 09/16/2025 at 2:14 PM, revealed the Cook's hair net was not covering the side or back of her hair. There was approximately eight inches of hair without covering.<br><br>During interview with the Cook at the time of the observation, she stated employees were to wear a hair net that covered all the hair when they were in the kitchen and around food. She further stated, "I have a lot of hair." She also stated the facility discussed the importance of covering hair about once a week.<br><br>During interview with the Director of Food Services (DFS) on 09/16/2025 at 2:15 PM, he stated the staff should wear hairnets or hats that covered the hair. He stated he just now saw the Cook's hair out of the hair net.<br><br>During interview with the Executive Director on 09/19/2025 at 2:03 PM, she stated she expected staff to follow the policies. She rounded periodically to assure policies are followed. | F0812 | Continued from page 6<br>Department Daily Huddle meeting a review of uniform appearance including wearing hairnets/hair coverings for both peer to peer and supervisor accountability.<br><br>4. a. An Ad Hoc Quality Assurance meeting was held on 9/29/25 with the Medical Director and the facility QAPI Committee to review the plan of correction and ensure the implementation of the plan.<br><br>b. On 12/22/25, the Director of Food Services or Assistant Director will begin audits to monitor employees to ensure wearing hairnets and hair covering correctly when working in the kitchen and food prep areas. Audits will include review of a minimum of 3 employees 3 times per week for three months.<br><br>c. Starting on 12/26/25, a Quality Assurance meeting will be held weekly for 4 weeks, then monthly for recommendations and further follow up regarding the above stated plan<br><br>d. The QA Committee will determine at what frequency any ongoing audits will need to continue. The Executive Director has the oversight to ensure an effective plan is in place to meet the residents' wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction. | |
| F0880 SS = D | Infection Prevention & Control<br><br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br><br>The facility must establish and maintain an infection | F0880 | 1.a. Resident 6 did not experience any negative effects from the deficient practice<br><br>b. On 9/22/25, the Director of Health Services provided re-education to RN 2 regarding Trilogy's Infection Prevention & Handwashing procedures for insulin | 12/19/2025 |

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| F0880 SS = D | Continued from page 7<br>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.<br><br>§483.80(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or<br><br>infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported.<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv)When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br><br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and | F0880 | Continued from page 7<br>administration, glove use, and hand hygiene.<br><br>2. a. All residents cared for by RN 2 have the potential to be affected by the deficient practice.<br><br>b. Between 9/22/25 and 9/28/25, the Director of Health Services monitored three staff members daily for insulin administration, infection control, glove use, and hand hygiene according to physician orders and Trilogy policy. Any non-compliance was immediately addressed with remediation and one-on-one re-education.<br><br>3. a. The Campus Clinical Support provided re-education to the ED, DHS, ADHS, MDS Coordinator, and IC Nurse on 9/22/25 regarding Trilogy's policy and procedures referencing insulin administration, infection control, glove use, and hand hygiene.<br><br>b. The Director and Assistant Director of Health Services, along with the Infection Control Nurse once trained, provided education to the nursing staff on Trilogy's policies for insulin administration, infection control, glove use, and hand hygiene from 9/22/25 to 10/22/25. Staff also were required to complete a post-test with this training, requiring a 100% passing score to confirm understanding.<br><br>c After 10/22/25, any newly hired Nurses and CMTs were and will be educated by the Director of Health Services or Assistant Director of Health Services regarding insulin administration, infection control, glove use, and hand hygiene with a post-test completed to ensure staff knowledge of the education provided was retained.<br><br>4. a. An Ad Hoc QAPI meeting was held on 9/29/25 with the Medical Director and the facility QAPI Committee to review the plan of correction.<br><br>b Beginning on 12/22/25, the DHS/ADHS/ICN will observe a staff member from each shift donning gloves and appropriate hand hygiene when administering insulin to a resident 5 times per week X 4 weeks, 3 times per week for 4 weeks, and 5 times for 1 month.<br><br>c Starting on 12/26/25, a Quality Assurance Performance Improvement meeting with the Medical Director and the facility QAPI Committee will be held weekly for 4 weeks, then monthly for recommendations and further follow up regarding the above stated plan. | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F0880 SS = D | Continued from page 8<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br><br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br><br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, record review, and review of facility policies, the facility failed to follow infection prevention and control practices to help prevent the development and transmission of communicable diseases and infection for 1 of 1 resident observed for subcutaneous injection administration. (Resident (R) 6.<br><br>The findings include:<br><br>Review of facility policy, "Infection Prevention and Control Program," revised 11/15/2021 and reviewed 12/17/2024 revealed its purpose was to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the transmission of communicable diseases and infections.<br><br>Review of the facility policy, "Specific Medication Administration Procedures/Injectable Medication Administration," revised 11/2018 revealed examination gloves were part of the equipment required for injectable medication administration. Further review revealed procedures for subcutaneous injections included to sanitize hands with approved hand sanitizer and put on gloves prior to administration.<br><br>Review of the facility's policy titled, "Guideline for Handwashing/Hand Hygiene," dated 03/20/2017 revealed | F0880 | Continued from page 8<br>d. The QA Committee will determine at what frequency any ongoing audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet the residents' wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction. | |

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| F0880 SS = D | Continued from page 9<br>all health care workers shall utilize hand hygiene frequently and appropriately and health care workers shall use hand hygiene before/after having direct physical contact with residents.<br><br>Review of Resident (R) 6's, "Face Sheet" revealed the facility admitted the resident on 02/20/2025 with diagnoses including type II diabetes and congestive heart failure (CHF).<br><br>Review of R6's "Comprehensive Care Plan (CCP)" dated 02/21/2025 revealed a risk for hypoglycemia/hyperglycemia related to a diagnosis of diabetes mellitus.<br><br>Observation on 09/17/2025 at 2:27 PM revealed Registered Nurse (RN) 2 entered R6's room and administered insulin subcutaneously to the resident. Observation additionally revealed R6 did not sanitize hands while in the room and administered the injection without gloves.<br><br>During an interview with Licensed Practical Nurse (LPN) 4 on 09/19/2025 at 12:45 PM, she stated prior to administration of any type of injection, she performed hand hygiene and put on gloves. She stated it was important to follow proper infection control procedures when she administered medication to help prevent transmission of germs.<br><br>During an interview with Registered Nurse (RN) 2 on 09/19/2025 at 12:56 PM, he stated he performed hand hygiene before he entered R6's room when he administered her insulin on 09/17/2025. However, he further stated he administered the insulin to R6 without gloves. RN2 stated it was important gloves were worn when injections were administered so cross contamination was controlled.<br><br>During an interview with the Infection Preventionist (IP) on 09/19/2025 at 1:15 PM, she stated infection prevention/control education was continual and ongoing. She stated she performed weekly audits and alternated between different areas of infection control, which included administration of injections. The IP stated it was her expectation staff used hand hygiene and put on gloves before they administered an injection so the exposure to infection was decreased. She further stated the facility was the residents' living environment and staff were responsible for them and their safety. | F0880 | | |

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| F0880 SS = D | Continued from page 10<br>During an interview with the Director of Health Services (DHS) on 09/19/2025 at 1:34 PM, she stated she expected staff to follow all infection control/prevention policies and procedures. She further stated the expectation was staff performed hand hygiene and put on gloves prior to administration of an injection. The DHS stated it was important gloves were worn because of the potential for bacterial transfer to a resident, as well the possibility of a needle stick to staff.<br><br>During an interview with the Executive Director on 09/19/2025 at 1:46 PM, she stated she expected staff followed facility guidelines when they gave injections. She further stated it was her expectation staff adhered to infection prevention and control policies during medication administration, so residents were kept safe from any blood borne pathogens. | F0880 | | |