DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT

NAME OF FACILITY: Wilmington Nursing & Rehabilitation Center DATE SURVEY COMPLETED: December 23, 2024

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Follow Up and Complaint Survey was conducted at this facility from December 17, 2024, through December 23, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 114. The sample totaled twenty-seven (27) residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed December 23, 2024: F561, F657,	**3201.1.2** Cross Refer to the CMS 2567-L survey completed December 23, 2024: F561, F657, F686, F689 and F880. Date of compliance: 1/15/2025	1/15/2025

Provider's Signature Renee Boyer Title LNHA Date 1/13/2025

NAME OF FACILITY: Wilmington Nursing & Rehabilitation Center **DATE SURVEY COMPLETED:** December 23, 2024

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Title 16 Health and Safety Chapter 11 Long-Term Care Facilities and Services Subchapter II Rights of Residents	F686, F689 and F880. **1123. Notice to resident.** **(a) The Department must prepare a notice that includes § 1121 of this title in its entirety. This notice must be available in a language and format that is accessible to each resident or their authorized representative under § 1122 of this title.** **(b) Each long-term care facility must post the notice described in subsection (a) of this section conspicuously in a public area of the facility.** **(c) Each long-term care facility must furnish copies of the notice required under subsection (a) of this section to all of the following:** **(1) Each resident upon admittance to the facility.** **(2) All residents currently residing in the facility.** **(3) Each authorized representative under § 1122 of this title.** **(d) The long-term care facility must retain in its files a statement signed by each individual listed in subsection (c) of this section that the individual has received a copy of § 1121 of this title.** This requirement was not met as evidenced by: Based on record review and interview, it was	**1123.** 1.R76 still resides at the facility. Resident Rights was audited and corrected. 2. All residents have the potential to be affected. The NHA/designee will audit for a signed copy or acknowledgement of the resident rights. Any missing will be corrected upon discovery. 3.The administrator and/or designee will educate Admissions, Social Services and Activities on the State requirement that all residents are provided with a copy of the Resident Rights. The root cause identified that the facility did not obtain a signature or acknowledgement of the updated Resident Rights. 4.The NHA and/or designee will audit all new admissions to verify a signed copy of the Resident Rights weekly x 4 until the facility reaches 100% consecutively and then 5	1/15/2025

Provider's Signature Renee Boyer Title LNHA Date 1/13/2025

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	determined that for one (R76) out of four residents reviewed for resident rights, the facility failed to furnish a copy of the residents' rights to R76 and retain a signed copy in the clinical record. Findings include: 1. R76's clinical record revealed: 4/29/24 – R76 was admitted to the facility. Review of R76's clinical record lacked evidence that R76 received and signed a copy of the Resident's Rights, per the State requirement. 12/19/24 3:14 PM – During an interview, E1 (NHA) confirmed the finding. 12/23/24 12:00 PM – Findings were reviewed during the exit conference with E1 and E2 (DON).	residents x2 months until the facility reaches 100% successfully. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5.Date of compliance: 1/15/25	

Provider's Signature Renee Boyer Title LNHA Date 1/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING _____ B. WING _____	R-C 12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD WILMINGTON, DE 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments An unannounced Annual and Complaint survey was conducted at this facility from September 19, 2024 through October 2, 2024. The facility census was 128 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Follow Up and Complaint Survey was conducted at this facility from December 17, 2024 through December 23, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 114. The sample totaled twenty-seven (27) residents. Abbreviations/definitions used in this report are as follows: CNA - Certified Nurses Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; MDS - Minimum Data Set/standardized assessment forms used in nursing homes; MG - Milligram (mg) - metric unit of weight, 1 mg equals 0.0035 ounce NP - Nurse Practitioner;	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/13/2025

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 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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{F 000}	Continued From page 1 RDCS - Regional Director of Clinical Services; PTA - Physical therapy assistant; RN - Registered Nurse; SW - Social Worker; UM - Unit Manager; Anemia - reduced ability of red blood cells to carry oxygen to organs causing tiredness; Colonoscopy -test to examine inside the colon using a thin, flexible tube; Edema -build-up of fluid causing swelling; Gastroenterology - medical specialty that focuses on the digestive system; Hematocrit - ratio of red blood cells to the total volume of blood; Hemoglobin (Hgb) - protein in red blood cells to carry oxygen from lungs to the body; Laceration - cut/tear in skin; Topical - applied directly to a part of the body. C. Difficile - Infection of the large intestine caused by bacteria that is highly contagious.	{F 000}		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		1/15/25

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F 561	Continued From page 2 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that one (R76) out of four residents reviewed for resident rights, the facility failed to identify and facilitate the resident's self-determination through support of resident choice with respect to his scheduled shower times. Findings include: R76's clinical record revealed: 4/29/24 - The admission MDS assessment documented that R76's response to "While you are in this facility, how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?" R76's response was "very important." 10/11/24 (last revised) - R76 was care planned for requiring one staff person assist for bathing. According to the November 2024 CNA Documentation Survey Report, R76 was scheduled showers every Tuesday and Friday	F 561	F561 Self Determination 1A. R76 continues to reside in the facility. 1B. All residents have the potential to be affected. NHA and/or designee will complete a full house interview with the resident and or responsible party for bathing preferences and preferred shift. 1C. MDS and or designee will provide education to those completing the MDS section F, Comprehensive Assessments. Verbalized preferences for showers, baths, or bed baths will be reflected in the care plan. 1D. Director of Nursing and/or designee will audit all new admissions residents weekly x 4 weeks, x2 monthly to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will	

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F 561	Continued From page 3 during day shift and as needed. However, closer review of the Report revealed that the report was setup for staff to document during day shift every Monday and Thursday and PRN (as needed). Four out of four scheduled opportunities from 11/18/24 to 11/30/24, no showers were provided to R76 nor was it documented that R76 refused. On Thursday, 11/21/24, staff documented that R76 received a shower during evening shift under PRN. Review of the December 2024 CNA Documentation Survey Report revealed that five out of five scheduled opportunities from 12/1/24 through 12/16/24, no showers were provided to R76 nor was it documented that R76 refused. 12/19/24 at 8:30 AM - During an interview, R76 stated that he hasn't had a shower since last month. When asked about his scheduled showers, R76 explained that he gets up early every day and was already dressed when the staff approach him about a shower. R76 explained that he does not refuse showers, but that he doesn't want to get undressed. 12/19/24 at 11:00 AM - During an interview, E18 (CNA) stated that R76 was already up and dressed when day shift starts care. E18 confirmed that R76 was scheduled for showers every Tuesday and Friday day shift. E18 stated that she tells the assigned nurse when he doesn't take a shower. 12/19/24 at 11:02 AM - During a combined interview with E4 (RN/UM) and E6 (RN/UM), E4 heard that R76 refused yesterday. Surveyor reviewed the November 2024 and December 2024 CNA Documentation Survey Reports where	F 561	determine the need for further audits and/or action plans. 1E. Date of Compliance: 1/15/25 2A. R76 continues to reside in the facility. Upon discovery, resident was offered a shower. 2B. All residents have the potential to be affected. NHA and/or designee will audit all residents to ensure that showers have been provided and/or there is a refusal documented. 2C. Unit Manager and/or designee will re-educate staff on checking the Kardex for shower days. If a resident refuses their preferences an alternate will be offered. If they continue to refuse, then CAN- will notify nursing. Nursing will then follow up with the resident and re-offer the preference. Further refusal will be documented in a progress notes. 2D. Director of Nursing and/or designee will randomly audit 10 residents weekly x 4 weeks, x2 monthly to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine the need for further audits and/or action plans. 2E. Date of Completion: 1/15/25	

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F 561	Continued From page 4 the CNAs are not documenting refusals. Surveyor asked if any nursing staff spoke with R76 to determine why showers were not being done and to determine his choice of a scheduled shower time. There was no response. Review of R76's nursing progress notes lacked evidence that staff identified and facilitated discussion with R76 to determine his choice of a scheduled shower time. 12/23/24 at 12:00 PM - Finding was reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 561		
{F 657} SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	{F 657}		1/15/25

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{F 657}	Continued From page 5 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R76) out of three residents reviewed for care plans, the facility failed to schedule and conduct a care plan conference after the quarterly MDS assessment with the Interdisciplinary Team members, R76 and R76's representative. Findings included: R76's clinical record revealed: 4/23/24 - R76 was admitted to the facility. 4/29/24 - The admission MDS assessment documented that R76's response to "While you are in this facility, how important is it to you to have your family or a close friend involved in discussions about your care?" R76's response was "very important." 10/7/24 - R76's quarterly MDS assessment was completed. Review of R76's clinical record after the 10/7/24 quarterly MDS assessment through December 20, 2024 lacked evidence that the facility scheduled and facilitated a care planning conference as required. 12/18/24 at 3:25 PM - During an interview, E19 (SW) confirmed that a care plan conference was not scheduled or held with R76 and R76's	{F 657}	F657 Care Plan F657 1. R76 continues to reside in the facility. Upon discovery, Care Conference was scheduled. 2. All residents have the potential to be affected by this practice. Social Services (SS) or Designee will audit all residents to ensure that Care Plan Meetings has been conducted and/or scheduled with resident and/or RP at a minimum Quarterly basis. 3. Root cause analysis was completed, concluded that a lack of understanding that Care Plan Meetings are to be conducted with all the necessary team members attending, such as dietary, activities and other support team members. NHA and/or designee will reeducate SS to ensure that all Care Plan meetings are to be conducted in conjunction with MDS assessments. Documentation is to reflect that a meeting has been scheduled and patient and/or a representative has been notified. Additionally, an invite will be provided to outside supports, such as hospice and	

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{F 657}	Continued From page 6 representative. When asked if the care plan and medication list are provided to the resident and resident representative, E19 stated that the resident and family representative can request copies. 12/23/24 at 12:00 PM - Finding was reviewed during the exit conference with E1 (NHA) and E2 (DON).	{F 657}	insurance representatives. Care conference schedules to be posted in PCC and discussed during morning meeting as a reminder to team members attendance. 4. NHA and/or designee will audit 10 residents weekly x 4 weeks and x3 monthly to ensure substantial compliance. Audits will consist of reviewing MDS schedule and care plan meeting to ensure that all residents have the assigned Care Plan meeting correlating with the completed MDS. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine the need for further audits and/or action plans. 5. Date of Completion: 1/15/25	
{F 686} SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	{F 686}		1/15/25

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{F 686}	Continued From page 7 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview an record review, it was determined that for two (R501 and R507) out three residents reviewed for pressure ulcer care, the facility failed to provide care to residents with pressure ulcers to promote healing. Findings included: 1. R501's clinical records revealed: 11/2/24 - R501 was admitted to the facility with diagnoses included an unstageable sacral ulcer. R501's wound care plan included, " ...Treatments as ordered ..." 11/20/24 - R501's physician's orders for wound care included, " ...Cleanse sacral wound with wound cleanser, apply medical grade honey and cover with bordered gauze every day ..." ..." 12/18/24 10:00 AM - A review of R501's treatment records lacked evidence that the sacral ulcer treatments were completed on 11/23/24,11/24/24 and 11/28/24 for a total of three out of 27 opportunities. 2. R507's clinical records revealed: 10/8/24 - R507 was admitted to the facility with diagnoses including stage 3 pressure ulcer to the left hip. R507's wound care plan included, " .... Treatments as ordered ..." 11/18/24 - R507's physician's wound care orders included, " ... Left hip - cleanse with Vashe (wound cleanser used to clean, moisten and debride wounds), lightly pack with Vashe soaked	{F 686}	F686 SS=D A. R501 no longer resides at the facility. No corrective action taken. R507 (R7) continues to reside in the facility. Resident seen by consulting wound care team on 12/18/24 with no decline noted in wound status. B. All residents with pressure ulcers care have the potential to be affected. The Director of Nursing or nurse manager audited all residents with pressure ulcers to ensure treatment was completed in the last 24 hours and documented correctly on the TAR. C. Root cause analysis noted that the staff member completed the care and did not document its completion on the TAR. The Director of Nursing or nurse manager will educate licensed nurses on completion of pressure ulcer treatment and documentation of completion on the TAR. The Medication Administration report will be pulled by the DON, ADON, UM and/or nursing supervisors to identify missing documentation. Any missing documentation will be reviewed with the staff member responsible to verify care was provided and ensure it is documented appropriately. D. The Director of Nursing or nurse designee will audit the Medication Administration report daily x 1 week to ensure documentation was completed until 100% compliance is obtained, then	

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{F 686}	Continued From page 8 gauze and cover with bordered foam daily ...." 12/18/24 11:30 AM - A review of R507's treatment records failed to show evidence that R507's left hip wound treatment was done on 12/14/24 for a total of one out of 18 opportunities. 12/23/24 12:00 PM - Findings were confirmed with E1 (NHA), and E2 (DON) during the exit conference.	{F 686}	weekly x 4 weeks until 100% compliance is obtained and then monthly x 3 months until 100% compliance is obtained. E. Date of Completion: 1/15/25	
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to provide an environment that was free of accident hazards. Findings include: 12/17/24 9:11 AM - An observation made during an initial tour of the Arcadia unit (secured dementia care unit) revealed that the lock to the staff dining room was broken. Inside the unlocked dining room, an additional observation revealed an unlocked cabinet that contained an opened box of diabetic lancets (small needles that are used to prick the skin to obtain a blood sample for people with diabetes). The opened box contained	{F 689}	F689 SS=D A. No residents were identified. The Lancets were immediately removed. B. All residents have the potential to be affected. An audit was conducted to ensure that all medical supplies are properly stored and all expired removed. C. Root cause analysis determined there was a lack of understanding that the lancet□s needed to be stored in a locked cabinet since the lock to the entrance of room was not functioning properly. The DON and/or designee reeducated the nursing staff on storing medical supplies	1/15/25

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{F 689}	Continued From page 9 a total of 18 packets of lancets, with 3 packets that expired in year 2023. The staff dining room was located across the hall from the Arcadia unit resident dining room and the room was accessible to anyone who attempted to enter the room through the unlocked door. 12/17/24 9:36 AM - During an interview, E15 (LPN) stated that the lock to the staff dining room had been broken for two weeks and E15 reported the broken lock twice. E15 confirmed the presence of the box of diabetic lancets in the unlocked cabinet. The facility failed to repair the staff dining room door lock in a timely manner, for more than two weeks. The presence of the lancets in the open cabinet inside the unlocked room presented a safety hazard to the residents and staff on the Arcadia unit. 12/23/24 12:15 PM - Findings were confirmed with E1 (NHA) and E2 (DON) during the exit conference.	{F 689}	properly in a locked and secured area. D. Staff Development and/or Designee will audit all cabinets to ensure that any medical supplies are in a locked and secured cabinet. Audits will be conducted weekly x4 and monthly x2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine the need for further audits and/or action plans. E. Date of Completion: 1/15/25 A. No residents were identified. The door lock was fixed. B. All residents have the potential to be affected by this practice. An audit was conducted on locked doors in resident care areas to ensure functioning properly. C. Root cause analysis determined there was a lack of understanding on the process of reporting a broken lock. Maintenance Director and/or designee educated nursing staff on how to properly report items to be fixed in TELS. Those without access to TELS are to report to the Unit Managers and/or Charge nurse who will enter into TELS. D. The Director of Maintenance and/or designee will audit all locking doors in patient care areas weekly x4 and monthly x2 to ensure substantial compliance. Results will be provided to the Quality Assessment and Assurance Committee for review and action as appropriate up until 100% compliance is met. The committee will determine the need for	

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	085028	A. BUILDING _____ B. WING _____	R-C 12/23/2024

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{F 689}	Continued From page 10	{F 689}	further audits and/or action plans. E. Date of Completion: 1/15/25	
{F 880} SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	{F 880}		1/15/25

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{F 880}	Continued From page 11 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for one (R505) out of three residents reviewed for infection control, the facility failed to establish and maintain an infection control program using contact precautions. Review of R505's medical record revealed a laboratory-confirmed diagnosis of	{F 880}	F880 SS=E F880 A. R505 still resides at the facility. B. All residents have the ability to be affected. Education was conducted on	

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{F 880}	Continued From page 12 Clostridioides difficile (C. diff) infection. According to the Centers for Disease Control and Prevention (CDC), C. diff requires strict contact precautions to prevent transmission, including the use of personal protective equipment (gowns and gloves) when entering the room of a resident with C. diff infection. Hand washing with soap and water is required before entering and after exiting the room, as alcohol-based hand sanitizers are not effective against C. diff spores. Findings Include: 12/18/24 10:30 AM - E20 was observed entering R505's room to ask for the lunch menu order. She failed to wear a protective gown and gloves per contact precautions guidance. She also failed to wash her hands before entering and after exiting R505's room. 12/19/24 11:00 AM - E14 was observed entering R505's room to retrieve soiled linen and garbage and finish mopping the floor without a proper protective gown and gloves per contact precautions guidance. E14 was also observed exiting the room without performing hand washing. 12/19/24 12:00 PM - During an interview, E10 (Staff Educator) stated that all employees were educated on infection control, including following contact precautions. Upon review of in-service records, neither E20 nor E14 had signed off on the education. 12/23/24 12:00 PM - Findings were confirmed with E1 (NHA), and E2 (DON) during the exit conference.	{F 880}	Environmental Services Staff and Kitchen Staff. C. Root cause analysis noted that the kitchen and EVS staff were not trained on the various isolation precautions. The Staff Developer was unable to quickly determine who was missing from various departments. The Director of Nursing created a specific department sign in sheet with every team members name entered. The form will be updated according to HR roster and updated by the scheduler. This form is over seen by the DON. The Director of Nursing or nurse manager to educate kitchen and environmental staff on isolation precautions including the personal protective equipment needed for each type of isolation precautions and needed hand washing requirements. D. DON and/or designee will audit 5 random isolation rooms during various times weekly x 4 weeks to ensure correct PPE is worn and appropriate hand hygiene is completed until 100% compliance is met; then monthly x 3 months to ensure correct PPE is worn and appropriate hand hygiene is completed until 100% compliance is met. E. Date of Completion: 1/15/2025	