STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Casper	**4041 South Poplar St , Casper, Wyoming, 82601**

(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
F0000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 7/13/26 through 7/16/26. Also reviewed in the course of the survey were complaint intakes: 1900505, 1900497, and 1900493. The following common abbreviations are used throughout this document: DON: Director of Nursing BIMS: Brief Interview for Mental Status MDS: Minimum Data Set CNA: Certified Nursing Assistant RN: Registered Nurse LPN: Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.	F0000		08/06/2026
F0689 SS = SQC-K	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 medical record review, observation, staff	F0689	F0689 PROBLEM STATEMENT: Life Care Center of Casper failed to ensure hot liquids were at a consumable temperature to prevent accident hazards for residents (#59) reviewed for accident hazards. This failure resulted in an injury to resident # 59 who received a burn from Green Chili that was provided by staff. The failure resulted in a determination of immediate jeopardy due to a lack of implementation of preventative measures CORRECTIVE ACTION: Community member #59 was assessed for injury on 7/12/26 and subsequently 7/14/26, with Pain/Skin UDA's, and event note documentation. MD was	08/11/2026

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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F0689 SS = SQC-K	Continued from page 1 and resident interview, facility incident review, and policy and procedure review, the facility failed to ensure hot liquids were at a consumable temperature to prevent accident hazards for 1 of 5 sample residents (#59) reviewed for accident hazards. This failure resulted in actual harm to resident # 59 who received a burn from hot liquid that was provided by staff. The failure resulted in a determination of immediate jeopardy due to a lack of implementation of preventative measures. The census was 70. The findings were: 1. Review of the quarterly MDS assessment dated 5/22/26 showed resident #59 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included difficulty swallowing, diabetes mellitus, peripheral vascular disease, anxiety, depression, and a history of bilateral below the knee amputation. Further review showed the resident was dependent upon staff for bed mobility such as, sitting on the side of the bed from a lying position. Review of the care plan last revised on 12/30/24 showed the resident was independent with eating. The following concerns were identified: a. Review of the incident report dated 7/12/26 and timed 11 AM showed the resident "...was eating a bowl of green chili, and tried to adjust in bed and spilled on [his/her] right thigh." Further review showed s/he had obtained redness and a nickel sized blister to the right thigh. b. Interview with resident #59 on 7/14/26 at 9:02 AM confirmed s/he had spilled a cup of green chili on him/herself while eating in bed on 7/12/26 which caused a blister on his/her right thigh. S/he revealed the chili had been served in a Styrofoam cup and while holding it, his/her thumb went through the cup, which resulted in the resident dropping the cup, and spilling the contents on his/her lap. c. Observation on 7/14/26 at 9:10 AM showed a dressing on the resident's right thigh dated 7/12/26. d. Interview with RN #1 on 7/14/2026 at 6:03 PM revealed she had made her own green chili at home, and would often bring it into the facility in a crock pot to share with the residents. She revealed she left the crock pot on the "warm" setting at 6 AM and did not check the temperature prior to serving it to the resident at 11 AM. Further interview confirmed she had served the green chili in a Styrofoam cup and when she returned to the resident's room at 11:15 AM she observed the green chili had spilled on the	F0689	Continued from page 1 notified of event and validated treatment orders. Therapy evaluated any specialty equipment needed, 100% audit to identify Community members who eat in their rooms, will be evaluated for any specialty equipment, Community Member diagnosis were reviewed, Identified Community members who already have equipment were reviewed for appropriateness, and Education was provided to all staff on ensuring to temp all food prior to giving it to the Community members, in association to “Hot Liquids” reviewed 05/04/2026, “Food from Outside Sources” reviewed 05/06/2025, and “Microwave Food Safety” policy Identification of others: All Community Member residing within Life Care Center of Casper have the potential to be affected. Systemic changes: LCCC will monitor “Microwave and Cook to Serve Temperature Log” for appropriate implementation of the “Food from Outside Sources”, Hot Liquid” and Microwave Food Safety policy/procedures. Current Employee’s will receive immediate education regarding the aforementioned policy’s and New Employees will be educated to the above policies during orientation and both existing and new employees will review aforementioned policies at yearly competencies. Generalized Nursing education in relation to identifying/treating Burns and identifying reportable incidents Monitoring: DON/Designee will audit “Microwave and Cook to Serve Temperature Log” weekly x 4 weeks then monthly x 90 days or until compliance achieved. Plan will be reviewed in QAPI x 3 months or until compliance achieved.	08/11/2026

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F0689 SS = SQC-K	Continued from page 2 resident's thigh, which caused redness and blistering. 2. Review of the policy titled "Food Safety" last revised 5/1/24 showed "The facility must...store, prepare, distribute and serve food in accordance with the professional standards of food service safety." 3. Review of the policy titled "Hot Liquids" last revised 5/4/26 showed "The food provided by the facility should be palatable, attractive, and at an appetizing temperature as determined by the type of food to ensure resident's satisfaction, while minimizing the risk for scalding and burns." and "Liquid Temperature and Burn Considerations...burns related to hot water/liquids may also be due to spills and/or immersion. Many residents in long-term care facilities have conditions that may put them at risk for burns caused by scalding. These conditions include: decreased skin thickness, decreased skin sensitivity, peripheral neuropathy, decreased agility (reaction time), decreased cognition or dementia, decreased mobility and decreased ability to communicate. The degree of injury depends on factors including water temperature, the amount of skin exposed, and the duration of exposure." 4. Interview with the DON on 7/14/26 at 11:53 AM revealed the facility was monitoring the resident's burn following the incident, however denied implementation of interventions for reoccurrence or that an investigation had been completed. 5. On 7/14/26 at 3:40 PM the regional vice president, the facility administrator, the regional director of clinical services, and the facility director of nursing were informed of an immediate jeopardy related to a failure to identify and remove accident/hazard risks to residents. 6. The facility submitted a removal plan on 7/15/26 at 9:40 AM which included: a. A root cause analysis was performed regarding the incident and identification of non-adherence to outside food temperature policy and microwave food safety serving temperatures was identified on 7/14/26. b. All at risk residents, including resident #59 were reviewed and assessed for adaptive equipment and the ability to manage self-feeding. Residents who required adaptive equipment were referred to occupational therapy for further evaluation on	F0689		08/11/2026

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F0689 SS = SQC-K	Continued from page 3 7/14/26. c. An ADHOC Quality Assurance/Performance improvement meeting was held with the medical director in attendance on 7/14/26. d. 1 to 1 education was provided to RN #1 on 7/14/26. e. Education was provided for nursing staff on 7/14/26 regarding the facility policy and procedures related to outside food brought into the facility, safe food temperatures not exceeding 155 degrees Fahrenheit for consumption, and reheating hot liquids. Further education included, serving food in appropriate containers to meet the residents needs and allowing food to cool to 155 degrees Fahrenheit prior to serving to residents. f. Temperature logs and thermometers were posted at each unit microwave on 7/14/26. g. All remaining nursing staff would be educated prior to their next scheduled work shift. 7. The removal plan was accepted on 7/15/25 at 9:49 AM. 8.The implementation of the removal plan was verified and immediacy was removed on 7/15/26 at 2:42 PM; however, deficient practice remained at a scope and severity of "G".	F0689		08/11/2026
F0565 SS = E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.	F0565	F0565 Problem Statement: Interviews conducted with 15 Community Members who attended Community council meeting on 7/14/26 at 2:10 PM revealed most Community Members felt staff did not follow up on their grievances with a resolution. Review of 22 grievance forms regarding missing personal items, water temperature, nursing, and staffing concerns over the last 4 months revealed 7 of the 22 grievances lacked documentation showing a resolution or follow-up outcome with the resident or representative. Corrective Action: Life Care Center of Casper immediately resolved two grievances regarding missing blankets, one from 3/13/26 and one from 5/13/26 by purchasing a replacement blanket for one resident that day and agreeing to reimburse another resident's daughter	08/24/2026

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F0565 SS = E	Continued from page 4 (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on resident and staff interview, grievance form review, and policy and procedure review, the facility failed to ensure the views of a resident or family group were considered and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. The census was 70. The findings were: 1. Interviews with 15 residents who attended resident council meeting on 7/14/26 at 2:10 PM revealed most residents felt staff did not follow up on their grievances with a resolution. 2. Review of 22 grievance forms regarding missing personal items, water temperature, nursing, and staffing concerns over the last 4 months revealed 7 of the 22 grievances lacked documentation showing a resolution or follow-up outcome with the resident or representative. 3. Interview with the administrator revealed no specific timeline for grievance resolution. The administrator stated the facility allowed the laundry department additional time to locate missing clothing, but attempted to resolve nursing or missing money concerns immediately. During the interview, this surveyor presented the administrator with several unresolved grievance forms dating back to 3/13/26 that lacked documented resident or representative follow-up. Upon this surveyor's request for these forms, the administrator	F0565	Continued from page 4 for reordering a replacement. The administrator reviewed the remaining grievance forms and confirmed that staff did not always resolve grievances in a timely manner. Additionally, identified truant grievance cards were addressed as follows: 1) Missing phone was replaced, identified missing hearing were not found, with new ones ordered and replaced on 5/29/26, missing sunglasses were replaced by facility, a missing jacket was found through laundry services, and shower temps were addressed via outside contractor identifying bad valves, with parts were ordered and part has recently been replaced Identification of Others: All Community Member residing within Life Care Center of Casper have the potential to be affected. Systemic changes: All current staff and with a focus on Facility managers were educated to “Grievance Program (Concern/Comment Policy) last reviewed 09/25/2023 on 7/21/2026, with new staff will receive continuing education regarding the Grievance Policy upon hire and All staff will receive continuing education during yearly competencies Monitoring: DON/Designee will audit/interview, as appropriate; any submitted Community Members Grievances weekly x 4 weeks then monthly x 90 days or until compliance achieved. Plan will be reviewed in QAPI x 3 months or until compliance achieved.	08/24/2026

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F0565 SS = E	Continued from page 5 immediately resolved two grievances regarding missing blankets, one from 3/13/26 and one from 5/13/26 by purchasing a replacement blanket for one resident that day and agreeing to reimburse another resident's daughter for reordering a replacement. The administrator reviewed the remaining grievance forms and confirmed that staff did not always resolve grievances in a timely manner. 4. Review of the facility policy titled “Grievance Program (Concern and Comment)” last revised 6/15/22 showed “...1. b. A reasonable expected time frame for completing the review of the grievance... Following up with resident and family to communicate resolution or explanation and ensure that the issue was handled to the resident and family’s satisfaction…Executive Director and/or Designee is responsible for the following:...Ensuring that all grievances and Concern & Comment Reports have been reviewed and addressed in a timely and appropriate manner and that concerned individuals feel that some type of resolution has been communicated, achieved and maintained…”	F0565		08/24/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F0755	F0755 PROBLEM STATEMENT: Review of the medical record for Community Member #17 showed the resident was admitted on 4/13/26 at 4:30 PM. Review of the progress note dated 4/13/26 and timed 5:29 PM showed the resident did not receive his/her diltiazem, gemfibrozil, and methocarbamol because it wasn't available. CORRECTIVE ACTION: Reviewed the admission and medication reconciliation process in conjunction with Omnicare policy/procedure in association with “Medication Shortage/Unavailable Medication” Policy Provided Education to Nursing Administration staff to perform a comparison of admitting medications versus available medication to identify readily non-available medication to coordinate acquiring identified medications from a Local pharmacy with adequate communication with the Community Member/Family, Staff, and Primary Physician. Identification of others: All Community Member residing within Life Care Center of Casper have the potential to be affected. Systemic changes:	08/11/2026

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F0755 SS = D	Continued from page 6 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure a pharmaceutical services procedure related to accurate acquiring, receiving, dispensing and administration of medications for 1 of 3 sampled residents (#17) reviewed for medication availability. The findings were: 1.Review of the admission MDS assessment dated 4/14/26 showed resident #17 had a (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included urinary tract infection, heart failure, high blood pressure, anemia, atrial fibrillation, anxiety disorder, respiratory failure, and shortness of breath. Further review of the nursing progress note dated 4/14/26 and timed 3:53 PM showed the resident was sent to the emergency room for shortness of breath and low oxygen saturation. The following concerns were identified: a. Review of the medical record showed the resident was admitted on 4/13/26 at 4:30 PM. Review of the progress note dated 4/13/26 and timed 5:29 PM showed the resident did not receive his/her diltiazem, gemfibrozil, and methocarbamol because it wasn't available. Review of the nursing progress note dated 4/13/26 and timed 6:15 PM showed the facility "did not have any of [his/her] medications at this time and [s/he] verbalized understanding". Review of the progress note dated 4/13/26 and timed 11:34 PM showed the resident did not receive his/her Bactrim [antibiotic] because it wasn't available. Review of progress note dated 4/13/26 and timed 11:35 PM showed the resident did not receive his/her simvastatin because it wasn't available. Review of progress note dated 4/13/26 and timed 11:36 PM showed the resident did not receive his/her propranolol or primidone because it wasn't available. Review of a progress note dated 4/13/26 and timed 11:37 PM showed the resident did not receive his/her pantoprazole or methocarbamol because it wasn't available. Review of progress note dated 4/13/26 and timed 11:38 PM showed the resident did not receive his/her	F0755	Continued from page 6 Facility will perform a 100% education for all Nursing staff capable of administering any medication, with a specific focus on Nurse Managers, for any Community Member within the facility with a specific focus on the Policy/Procedure “Medication Shortage/Unavailable Medications” of newly admitted Community Members, in comparison of available in-house Medication list, New and Existing employees will receive continuing education regarding “Medication Shortage/Unavailable Medications”, per LCCA, upon hire and during yearly competencies Monitoring: DON/Designee will audit 2 Community Members (as available) who were admitted into Life Care Center of Casper for in-house available medications versus admitting orders, communication documentation for the corresponding week x 4 weeks, then monthly x 90 days or until compliance achieved. Plan will be reviewed in QAPI x 3 months or until compliance achieved.	08/11/2026

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F0755 SS = D	Continued from page 7 famotidine because it wasn't available. Review of progress note dated 4/13/26 and timed 11:39 PM showed the resident did not receive his/her AZO cranberry or apixaban because it wasn't available. Review of progress note dated 4/13/26 and timed 11:41 PM showed the resident did not receive his/her diltiazem because it wasn't available. Review of progress note dated 4/13/26 and timed 11:45 PM showed the facility was "unable to give medications as not available, outside pharmacy did not bring any...and would not add [him/her]. Resident aware." Review of the progress note dated 4/14/26 and timed 9:04 AM showed the resident did not receive his/her AZO cranberry or gemfibrozil because it was "On supply from the pharmacy." Review of the medication administration record confirmed the resident had not received the medications. b. Interview with the DON on 7/15/26 at 4:07 PM revealed the resident was admitted with medication orders which should have been sent to the contracted pharmacy. He confirmed the resident had missed medication doses, but could not provide a rationale. Further interview revealed nursing staff were expected to pull medications from the facility's "emergency 'kit" located in the Omnicell (An automated, computerized cabinet or system used in hospitals and healthcare facilities to securely store, manage, and dispense medications and medical supplies) if the contracted pharmacy had not sent them to the facility. c. Interview with the DON on 7/16/26 at 2:17 PM revealed the facility admissions team was responsible for sending medication orders to the primary pharmacy, but could not provide evidence the admissions team had sent the orders. Further interview revealed if the pharmacy couldn't deliver the medications to the facility, the prescriptions should have been sent to a local contracted pharmacy until the primary pharmacy could deliver them to the facility. d. Interview with the admissions director on 7/16/26 at 2:24 PM revealed the resident's medication orders should have been faxed to the primary pharmacy prior to the resident's admission and a call should have been placed to verify the pharmacy had received them, but she could not provide evidence the orders were faxed. e. Interview with LPN #1 on 7/16/26 at 4 PM confirmed the facility had not received the resident's medications from the pharmacy and she did not pull the medications from the "emergency kit" located in the Omnicell.	F0755		08/11/2026

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F0755 SS = D	Continued from page 8 2. Review of the policy titled “Medication Shortages/Unavailable Medications” last revised 8/1/24 showed “...3. If a medication is unavailable or discovered after normal pharmacy hours…A facility nurse should obtain the ordered medication from the Emergency Medication Supply, the licensed facility nurse should call Pharmacy’s emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include…Emergency delivery or use of an emergency (back-up) third party pharmacy.”	F0755		08/11/2026
F0880 SS = D	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;	F0880	F0880 PROBLEM STATEMENT: Community Member # 4 had two staff, CNA #1,2 entered the Community member’s room with a mechanical lift, Staff attached the lift sling to the mechanical lift without applying PPE(i.e. gloves) or other PPE. CNA #2 was witnessed an ungloved hand to lift the resident’s catheter drainage bag. CNA then hung the catheter bag on the mechanical lift and CNA #1 lifted the resident out of the recliner and positioned the lift over the resident’s wheelchair, then without performing hand hygiene, CNA #2 grabbed the resident’s wheelchair handles to reposition and stabilize the chair. CNA #1 used her ungloved hand to remove the drainage bag from the mechanical lift and placed the bag under the resident’s wheelchair, without performing hand hygiene and without gloves. The staff prepared to exit the resident’s room by touching his/her pants, shirt, wheelchair, foot pedal, and mechanical lift controls. Further observation showed no hand hygiene was performed before exiting the room. CORRECTIVE ACTION: Completed 100% audit of all Community Members utilizing EBP precautions for use of appropriate PPE with identification/signage and available PPE equipment. education was provided to the immediate staff providing cares of Hand Washing and Enhanced Barrier Precautions policy/procedure per LCCA, with subsequent all staff education for hand washing and EBP protocol Identification of others: All Community Member residing within Life Care Center of Casper have the potential to be affected.	08/11/2026

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(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
F0880 SS = D	Continued from page 9 (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, medical record review, staff interview, and policy and procedure review, the facility failed to ensure infection prevention practices were implemented for 1 of 5 sample residents (#4) observed for resident care. The findings were: 1. Observation on 7/15/26 at 3:56 PM showed CNA #2 and CNA #1 entered resident #4's room with a mechanical lift. The CNAs attached the lift sling to the mechanical lift and without applying gloves or other personal protective equipment. CNA #2 used her ungloved left hand to lift the resident's catheter drainage bag. The CNA hung the drainage bag on the mechanical lift and CNA #1 lifted the resident out of the recliner and positioned the lift over the	F0880	Continued from page 9 Systemic changes: DON/Designee will provide 100% staff education regarding Hand Hygiene, PPE and Enhanced Barrier Precautions, New and Existing employees will receive continuing education regarding PPE/EBP and Hand Hygiene protocol/procedures, per LCCA, upon hire and during yearly competencies Monitoring: DON/Designee will audit 5 of Community Members who require Physical Assistance with Activities of Daily Living, with a focus on Catheter manipulation, and Mechanical lift use for adherence to appropriate PPE application, Hand Hygiene, and EBP adherence weekly x 4 weeks then monthly x 90 days or until compliance achieved. Plan will be reviewed in QAPI x 3 months or until compliance achieved.	08/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535049	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2026

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F0880 SS = D	Continued from page 10 resident's wheelchair. Without performing hand hygiene, CNA #2 grabbed the resident's wheelchair handles to reposition and stabilize the chair. At that time, CNA #1 lowered the resident into the wheelchair and without wearing gloves, CNA #1 used her ungloved hand to remove the drainage bag from the mechanical lift and positioned it under the resident's wheelchair. Without performing hand hygiene, the CNAs prepared the resident to exit the room by touching his/her pants, shirt, wheelchair foot pedals, and the mechanical lift controls. Observation showed CNA #2 exited the room pushing the resident's wheelchair and CNA #1 pushed the mechanical lift into the hall. Further observation showed no hand hygiene was performed before exiting the room. 2. Interview with the infection preventionist on 7/16/26 at 10:17 AM revealed enhanced barrier precautions should have been used when providing care to a resident with a catheter, even during a mechanical lift transfer. She revealed she expected hand hygiene to be performed after touching a catheter drainage bag and before exiting a resident's room. 3. Review of the policy titled "Indwelling Urinary Catheter (Foley) Management" last revised on 9/4/25 showed "...General Urinary Catheter Maintenance Guidelines ...3. Use personal protective equipment, including the use of gloves and gown as appropriate, during any manipulation of the catheter or collection system..." 4. Review of the policy titled "Hand Hygiene" last revised on 7/15/22 showed "... When to perform proper hand hygiene with (ABHR) and with soap and water;.. Before and after all resident contact; After contact with potentially infectious material;.. After contact with objects in the resident's room;.. It is important to make sure that hand hygiene is performed at the appropriate times before and after touching a resident, between residents and frequently during care..."	F0880		08/11/2026