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F0000 SS=	INITIAL COMMENTS The Laurels of Hudsonville Facility was surveyed for a Recertification and Complaint survey on 7/14/23. Intakes: MI00130761, MI00130763, MI00130896, MI00131523, MI00131830, MI00132473,MI00132675, MI132773, MI00132838, MI00133178, MI00133192, MI00133653, MI00135286, MI00133533, MI00136535, MI00136536, MI00138260. Census = 83	F0000		
F0610 SS= D	Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to timely and thoroughly investigate an injury of unknown origin for one resident, Resident #14 (R14) reviewed for injuries. This deficient practice	F0610		

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

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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resulted in R14 sustaining a second degree burn to the hand that was not reported nor investigated timely with the potential for repeated injuries to occur.

Findings include:

The facility provided the policy for Hot Liquids and Foods dated 8/1/2011, last revised on 11/1/2011 for review. The policy reflected, "4. If a spill occurs the following procedure will be followed: Cool the area as quickly as possible by flushing with cold water immediately ...Follow facility procedure for incident reporting ..."

The facility provided the policy for Abuse Prohibition Policy dated 12/1/2012, last revised on 10/14/2022 for review. The policy reflected, the definition of, "Injuries of unknown source - An injury should be classified as an "injury of unknown source" when ALL of the following criteria are met: The source of the injury was not observed by any person; and the source of the injury could not be explained by the guest/resident; and the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the extent of the injury, or the injury is located in an area not generally vulnerable to trauma), or the number of injuries observed at one particular point in time of the incidence of injuries over time ...E. Investigation ...3. An Incident Report (and/or grievance forms per state specific requirements) will be completed ...5. A preliminary, on-site investigation will be initiated within twenty-four (24) hours of any report ..."

R14

Review of the Face Sheet and Minimum Data Set (MDS) dated 7/11/23 revealed R14 admitted to the facility on 5/13/23, with diagnosis of (but not

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	limited to) cerebral palsy, epilepsy, and intellectual disability. Brief Interview for Mental Status (BIMS) reflected a score of 6 out of 15 which represented R14 had severe cognitive impairment. R14 required staff assistance with all activities of daily living. During an observation and interview on 7/12/23 at 11:14 AM, R14 reported to the Surveyor that she had burned her hand "last week" while in her room. R14 stated she is taking "capsules" for the pain and removed the dressing to show the Surveyor the burn. A reddened area was observed to the left dorsal hand that was missing the top layer of skin and was approximately 2 inches in length with an hourglass shape to it. The progress notes were reviewed on 7/13/23 at 12:00 PM regarding the injury. There was one note dated 7/11/23 at 9:58 AM that reflected, "Resident came to nurse office stated her wrist hurt, stated she thinks she spilt hot coffee this a.m. Area on top of wrist was burned. Resident is at her baseline. Unit Manager dressed the area." The Hot Liquid Safety Assessment completed by the facility on 5/15/23 reflected, "Resident may drink hot liquids with supervision with 2 handled mugs with lid and straw." The Skin and Wound Evaluation dated 7/11/23 at 9:38 AM was reviewed on 7/13/23 at 9:45 AM. The evaluation reflected a second degree burn that measured 2.5 cm x 1.5 cm. The wound evaluation had multiple areas not completed such as the wound bed, wound pain, treatment, nor the notification of the physician or guardian sections. The wound evaluation was not "locked" at the time of this review (over 48 hours after the incident occurred). The facility failed to complete a thorough and timely wound evaluation.			

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	On 7/13/23 the DON provided a copy of the IDT noted dated 7/13/23 at 1:39 PM (over 48 hours after the burn occurred) that reflected, "IDT note following burn to left top dorsum 1st digit. Resident to have hot liquids with supervision in activities with a Kennedy cup only, care plan updated." On 7/13/23 the DON provided a copy of the Incident Report dated 7/11/23 at 9:47 AM that reflected, "Resident came up to Unit managers office and stated her left wrist hurt. Noted a small burn area on top of wrist area ...Resident stated she thinks she spilt hot coffee on her wrist." The boxes for "confused" and "impaired memory" were checked. Under Predisposing Situation Factors the "other" box was checked but no description was listed. When asked where and how the incident occurred, the DON stated, "It doesn't say." When asked if there were any witnesses to the event, the DON stated, "I don't think so." During an interview on 7/13/23 at approximately 2:00 PM, the NHA stated that she spoke with R14 today (7/13/23) and R14 told her that she reached into the food cart in the hall and spilled hot coffee on herself. When asked about the R14's severe memory impairment and ability to recall an event that happened over 48 hours ago, the NHA stated that is what she is recalling now. The facility failed to complete a thorough and timely incident report and investigation of an injury of unknown origin to facilitate a plan of care for preventing a reoccurrence.			
F0656 SS= D	Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2)	F0656		

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	and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:			

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	Based on interview and record review, the facility failed to develop a dietary care plan for 1 (Resident #69), resulting in the potential for confusion for a resident with dysphagia to not have the appropriate care needed for meals. Findings include: Review of the Orders for R69 revealed orders dated 6/15/23 for Nepro (enteral nutrition via tube feeding) and for a mechanical soft diet, mechanical soft texture, and thin liquids. In an interview on 7/13/23 at 8:00 AM, Speech Therapist (ST) "K" reported R69 is on a mechanical soft diet with thin liquids for dysphagia and does require supervision with meals. She recommended that medications be crushed and pureed for safety. The physician can have the final say to change the diet but would not recommend swallowing whole pills. Review of the Care Plan for R69 revealed "Provide diet as ordered: NPO (nothing by mouth)." Another intervention included the resident is to have a Kennedy cup and built-up utensils during meal with supervision from caregivers. There are no interventions in the care plan indicating a mechanical soft diet, mechanical soft texture, and thin liquids were appropriate for the resident.			
F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan,	F0684		

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	and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation pertains to intake M100136178 & MI00132675 Based on observation, interview and record review, the facility failed to assess, monitor, treat and coordinate care for 2 (Resident #69, Resident #87), resulting in the lack of coordination in treatment for altered skin integrity for R69 and skin breakdown for R87. Findings include: Resident #69 (R69) Review of a Face Sheet revealed R69 originally admitted to the facility on 3/18/23 with pertinent diagnoses of an intracerebral hemorrhage, hemiplegia, and hemiparesis (one sided weakness), and diabetes. Review of the Minimum Data Set (MDS) dated 6/22/23 revealed she is severely cognitively impaired and requires extensive assistance of two staff for transfers and one staff for cares. Review of a Care Plan for R69 revealed weekly head to toe skin assessments are to be done and to report new/abnormal findings to physicians as needed. A revision to the Care Plan on 4/26/23 revealed that she is also at risk for impairment to skin integrity due to incontinence. Review of a Nursing Progress note dated 6/26/23 for R69 revealed the daughter noticed the resident buttock wounds appeared to be more moist and excoriated and requested a triad (topical cream) to be discontinued and a new treatment ordered. The			

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unit manager will add the resident to weekly wound rounds. An order for foam dressings was placed. (order was placed for daughter's benefit). No nursing assessment documented.

Review of the Treatment Administration Record (TAR) for R69 revealed an order dated 6/26/23 to cleanse bilateral buttock wounds with normal saline and apply a foam dressing every 72 hours for wound care.

Review of Skin Assessments dated 6/28/23 and 7/5/23 revealed no new wounds.

In an interview on 7/12/23 at 10:00 AM, Family Member (FM) "J" reported the dressing changes for R69 was supposed to be stopped and this past Sunday (7/9/23) the resident had a mepilex dressing in place. The resident had two opened sores 3 weeks ago that healed.

During an observation on 7/13/23 at 12:08 PM, R69 was in bed and staff were providing incontinence care. R69 had an undated 2X2 gauze covered with a clear telfa dressing on both the right and left buttock. Registered Nurse (RN) "F" reported she had already done a dressing change for R69 earlier this day. RN "F" removed the dressings and approximately a golf ball sized pink, un-blanchable area near the inner cleft of the buttock near the anus on both sides was noticed. There was a small slit/open area approximately the size of a pencil eraser observed. The surrounding skin was blanchable. RN "F" cleansed the skin with normal saline and redressed both sides of the buttocks with the 2X2 gauze covered with a telfa dressing. There were no orders for telfa dressings noted.

In an interview on 7/13/23 at 1:05 PM, the Physician (MD) "I" reported there were no notes for R69 indicating a need for wound care and he

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was not notified of any wounds. The physician then assessed R69 and confirmed she did not have a pressure ulcer but did have Moisture Associated Skin Damage (MASD) and discontinued the dressing changes in the computer. MD "I" reported the adhesive from the dressing changes could be pulling at the skin and make the outer edges fray. He is going to change the orders in the computer that the Physician Assistant ordered for a barrier cream. MD "I" could not find any documentation to justify the dressing order. The daughter who was DPOA insisted the order to be placed and the facility staff implemented the orders based on her request.

Resident #87 (R87)

Review of R87's face sheet dated, 7/12/23 revealed he was a 63-year-old male, admitted to the facility on 7/20/23 and had diagnoses that included: quadriplegia (loss of movement of arms and legs), neuromuscular dysfunction of bladder (loss of bladder function) and dysphagia (difficulty swallowing). R87 was his own responsible party.

Review of the facility "Skin Management" policy dated, last revised 7/14/21 revealed, "It is the policy that the facility should identify and implement interventions to prevent development of clinically unavoidable pressure injuries. 4. Guests/residents admitted with any skin impairment will have: Appropriate interventions implemented to promote healing. A physician order for treatment, and wound location, measurements and characteristics documented. 8. The licensed nurse will document preventative measures on the care plan/Kardex. 11. A weekly total body skin evaluation is completed for each guest/resident by the licensed nurse. The licensed nurse with document findings of the skin evaluation. The CNA's will report any new skin

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	impairment to the licensed nurse that is identified during daily care. Review of R87's "Nursing Comprehensive Evaluation" dated 7/20/22 revealed he was admitted to the facility on 7/20/22. R87 had an indwelling catheter and was incontinent of bowel and bladder. R87 required the assistance of two people for transfers, bed mobility, toileting, he could not walk. Skin section revealed, "R87 has actual impairment to skin integrity r/t (related to) incision site to Lt (left) mid scalp, abrasion t Rt (right) leg/knee and C4 spine region." Under site revealed, "right scapula, right lower leg front, back of head, C4 region, dressing clean, dry and intact to Rt (right) side, abrasion noted, OTA (unknown), Lt mid scalp healing incision site." No description additional description of skin abnormalities could be located. There was no indication of any skin issues on R87's buttock. Review of R87's "Skin & Wound - Total body Skin Assessment" dated 9/21/22 at 6:00 AM revealed no skin break down or skin concerns. During an interview with the Director of Nursing (DON) on 7/13/23 the DON said she reviewed R87's medical record and found no indication he had any skin break down or skin concerns on his buttock while he was in the facility. DON said the last skin assessment was completed on 9/21/22 and they do not document the residents skin condition when they send someone to the emergency room. The Surveyor shared the emergency room skin assessment. The DON responded you can get a full thickness skin injury within 2 hours. The DON verified there was no indication the facility was aware of skin breakdown and had no treatment in place for moisture associated skin breakdown on R87 buttock prior to his discharge on 9/23/22.			

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	Review of R87's Kardex dated admission 7/20/22, as of 7/13/23 revealed no indication any preventative treatment was in place of moisture associated skin issues on R87's buttock. Review of R87's care plan revealed, "R87 is incontinent of bladder and bowel R/T (related to) C4 Spinal cord injury. Date initiated 7/20/22. Interventions included: Brief usage, check q 2 hr (hour) and prn (as needed) for incontinence. Wash, rinse, and dry perineum. Change clothing after incontinence care as need. Foley catheter. Review of R87's transfer form dated 9/23/22 revealed he was transferred to the hospital on 9/23/22 at 8:00 AM. Review of R87's hospital emergency room face sheet dated 9/23/22 revealed he arrived in the emergency room on 9/23/22 at 8:49 AM and he was admitted at the same time. Review of R87's emergency room skin assessment revealed he had a 4 cm linear full thickness wound in the gluteal cleft with beefy red base and peeling edges and a partial thickness wound with a pink base that was 2 cm in diameter with irregular edges on his right buttock. The Emergency room report included photographs of these wounds found on admission. Under diagnosis revealed, "moisture associated skin damage from stool incontinence. At risk for pressure injuries." Under Assessment/Plan, revealed, "Cannot exclude underlying pressure but given multiple liquid stools there is more likely hood of moisture etiology to these denuded areas of gluteal cleft and right buttock. Recommend zinc barrier (orange top) for gluteal cleft/buttock wounds and to protect scrotum from frequent clean ups recommend Vaseline skin protectant (blue top)."			

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F0689 SS= D	Free of Accident Hazards/Supervision/Devices §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 observation, interview, and record review, the facility failed to safely transport a resident (R185) in a wheelchair, resulting in the potential for serious injury. Findings include: A review of R185's Admission Record, dated 7/12/23, revealed R185 was a 59-year-old resident admitted to the facility on 7/10/23. In addition, R185's Admission Record revealed multiple diagnoses that included generalized muscle weakness, abnormal gait and mobility, and weakness. A review of R185's fall risk care plan, dated 7/10/23 and revised on 7/11/23, revealed R185 was at risk for falls and fall-related injuries due to bilateral lower extremity (both legs) weakness. On 7/12/23 at 9:16 AM, R185 was observed in the hall in a wheelchair without foot pedals. The wheelchair was being propelled forward by a visitor as the Resident held her feet off floor. Staff were observed walking past R185 being pushed without stopping to attach foot pedals to the wheelchair or attempting to assure the Resident's safety. During an observation on 07/13/23 at 9:50 AM, a	F0689		

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visitor was pushing R185 down the 400 Hall toward the nurse's station without foot pedals on the wheelchair. R185's feet were occasionally touching the floor and she would lift them up again. As the visitor was pushing R185 down the hallway, they passed pushed past Staff Development/Inservice Director (SDID) "C". The surveyor pointed out the visitor pushing R185 to SDID "C", SDID "C" confirmed that the resident was R185, and then SDID "C" walked away from the surveyor to go into the Director of Nursing (DON) office without saying anything to the visitor or stopping the visitor from pushing R185 in her wheelchair without foot pedals.

During an interview on 07/13/23 at 10:45 AM, the facility's policy and procedure on transporting residents in a wheelchair was requested from the DON. The surveyor also asked the DON if a resident should have foot pedals on their wheelchair when being pushed down the hallway and she stated "yes".

During an interview on 07/13/23 at 10:55 AM, Licensed Practical Nurse (LPN) "A" stated residents are supposed to have foot pedals on their wheelchairs when they are being pushed by staff or visitors. She stated, "It shouldn't happen, but I know it does." LPN "A" also stated if she sees someone pushing a resident's wheelchair without foot pedals, she will stop them and tell them they need to get foot pedals on the wheelchair before they continue pushing them. LPN "A" shared with the surveyor that during her nursing career she had seen residents in the past who were pushed without foot pedals, their feet caught on the ground, and they flipped forward out of the wheelchair. She stated some of those residents sustained serious injuries.

During an interview on 07/13/23 at 11:00 AM, housekeeper (HSK) "B" stated residents should

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	704050	A. BUILDING _____ B. WING _____	7/14/2023

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LAURELS OF HUDSONVILLE (THE)	3650 VAN BUREN HUDSONVILLE, MI 49426

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	have foot pedals on their wheelchairs when they are being pushed. She stated if she saw a resident being pushed without foot pedals, she would stop them and have whoever was pushing the resident get foot pedals before continuing on. During an observation on 07/13/23 at 11:10 AM, R185 was sitting on her bed and was having a discussion with a therapy professional. R185's wheelchair was observed without foot pedals attached next to her bed. Therefore, R185's wheelchair clearly did not have foot pedals that were being used. During an interview on 07/13/23 at 02:26 PM, the DON stated the facility does not have a policy or procedure on how to transport a resident in a wheelchair. She stated they do not have any documentation that staff are educated on how to transport residents in wheelchairs, including not to push residents in wheelchairs without foot pedals. In addition, the DON stated the facility also does not have competency skills checklists that include wheelchair transportation.			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for	F0812		

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	food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the kitchen and the equipment were being maintained free of dust, dirt, food residues and other contaminates, and that the equipment was maintained in proper working order, resulting in the potential to affect all residents that receive food and beverages from the kitchen. Findings included: During a follow-up tour of the kitchen on 7/13/23 at 10:21 AM, the following physical facility and equipment observations were found in the kitchen and storage areas: 1.) The floors in the kitchen, dry storage area, and Walk-In- Units including under equipment, storage racks and along the floor/wall junctures had an accumulation of dust, dirt, dead bugs, ice, food residues and other debris. 2.) The walls in these areas were found to have stuck on food residues, dust, dirt, mold, mildew, dust, and other debris. 3.) Observation of the Walk-In-Units reflected dust, dirt, ice, mold, mildew and food debris on the compressor unit's grates and fans and on the shelving units. 4.) The large fans located in the dish area and kitchen were dusty and dirty. 5.) The "clean" dish storage shelving was dusty, dirty and had cobwebs. According to the 2017 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. "(A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean." According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. ... "(C)			

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	NONFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris." During the follow-up tour the following equipment was observed not being properly maintained: 1.) the leaking water lines on the coffee machine. 2.) The end well (left side) on the steamer unit was observed not maintaining the water/temperature and was leaking onto a saturated blanket located on the shelf directly below the steam wells . According to the 2017 FDA Food Code section 5-205.15 System Maintained in Good Repair. "A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; P and (B) Maintained in good repair." According to the 2017 FDA Food Code section 4-501.11 Good Repair and Proper Adjustment. (A) Equipment shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. An initial tour of the kitchen was conducted on 7/11/23 at approximately 10:00 am with the Certified Dietary Manager (CDM) "D". At the start of the tour the CDM "D" stated that he had submitted a work order for the freezer because it was leaking. Upon inspection of the freezer, it was noted the compressor mounted to the ceiling was leaking frozen fluid onto a box of food stored directly under it. The CDM "D" stated the food in the box could not be served and stated it needed to be removed. A box of chicken nuggets was observed to be turned on its side and 5-6 nuggets had spilled on to the storage shelf and an ice cream cup was on the floor of the freezer.			

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F0880 SS= D	Infection Prevention & Control §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 §483.70(e) 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; (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	F0880		

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	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, the facility failed to implement best infection control practices after providing care for 1 (Resident #69), resulting in the potential for spreading infection. Findings include: Resident #69 (R69) Review of a Face Sheet revealed R69 originally admitted to the facility on 3/18/23 with pertinent diagnoses of an intracerebral hemorrhage, hemiplegia, and hemiparesis (one sided weakness), and diabetes. During an observation on 7/13/23 at 12:08 PM, R69 was in bed and staff were providing incontinence care. Registered Nurse (RN) "F" completed a dressing change on the resident's buttocks and left the room after ungloving her hands and carried a half empty bottle of normal saline down the hall to the medication cart where she disposed of the bottle and continued down the			

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	with no hand hygiene. In an interview on 7/13/23 at approximately 1:30 PM, RN "F" confirmed she did not perform hand hygiene after performing a dressing change on R69, before leaving the room, or after the disposal fo wound supplies in the hallway.			