STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	07/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHRIS JENSEN HEALTH & REHABILITATION CENTER	2501 RICE LAKE ROAD DULUTH, MN 55811

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to handle ice under sanitary conditions, to prevent cross contamination from infectious sources. This practice had the potential to affect all 37 who resided on the Cedar unit at the facility. Findings include: According to the Minnesota Department of Health (MDH) website https://www.health.state.mn.us/diseases/crab/index.html undated, Carbapenem-resistant Acinetobacter baumannii (CRAB) is a type of bacteria commonly found in the environment, especially in soil and water. CRAB can cause human infections of the blood, urinary tract, lungs, wounds, and other body sites. The bacteria are multidrug-resistant, making infections very difficult to treat. R1's Admission Record dated 7/23/20, indicated R1's [DIAGNOSES REDACTED]. R1's quarterly Minimum Data Set ((MDS) dated [DATE], identified R1 required extensive assistance with bed mobility, transfers, locomotion, and toilet use. R1's MDS further identified he had an indwelling catheter and was frequently incontinent of bowel. R1's care plan dated 1/27/16, indicated R1 had a chronic indwelling Foley catheter related to [MEDICAL CONDITION] (prostate gland enlargement). R1's care plan dated 1/8/20, indicated R1 had a history of [REDACTED]. Staff were to adhere to enhanced barrier precautions (use of gowns and gloves beyond situations in which exposure to blood and body fluids is anticipated) to prevent infection. A progress note dated 3/20/20, at 5:03 p.m. indicated the facility was notified R1 had tested positive for CRAB. R7's Admission Record dated 7/23/20, indicated R7's [DIAGNOSES REDACTED]. On 7/21/20, at 8:57 a.m., an enhanced barrier precaution sign was noted to be posted on R1's outer room door. A white plastic three drawer bin was noted, outside of R1's room, which contained personal protective equipment (PPE) supplies. On 7/21/20, at 9:42 a.m., an interview was conducted with nursing assistant (NA)-F. NA-F stated enhanced barrier precautions were used for R1 because he was diagnosed with [REDACTED]. Nursing assistant (NA)-E walked towards R1's room, and put on an isolation gown and gloves. NA-E entered R1's room, and R1 asked for water. On 7/21/20, at 11:29 a.m. NA-E exited R1's room with a large plastic mug which was partially filled with water. NA-E held the large plastic mug against her upper uniform shirt by using both of her forearms (hugging motion). NA-E walked down the hallway and entered R24 and R36's room. A staff person who was inside R24 and R36's room asked NA-E about the mug. The staff person stated another cup needed to be used to fill the mug. NA-E exited R24 and R36's room and walked towards the Cedar nurses' station. NA-E opened a door near the Cedar nurses' station, which indicated Staff Only. NA-E entered the room and removed the lid from the mug. NA-E poured water from the mug into the sink. NA-E then opened a white ice cooler which was on a rolling cart. NA-E obtained a scoop which was on the side of the cooler, and transferred ice from the cooler to the mug. NA-E placed the scoop inside the mug, and the scoop made direct contact with the inner surface of the mug. NA-E removed the scoop from the mug, and used it to obtain additional ice from the cooler. NA-E again placed the scoop on the inside of the mug, and made contact with the inner surface. NA-E closed the cooler lid and placed the scoop in a holder on the side of the cooler. NA-E used the sink faucet to fill the mug with water, and replaced the plastic lid. NA-E exited the Staff Only room and walked towards R1's room. NA-E placed the mug on top of the white plastic three drawer bin outside of R1's room. NA-E was interviewed at that time and confirmed the mug belonged to R1, and she removed the mug from R1's room when he requested it to be refilled. NA-E stated R1 was placed on enhanced barrier precautions due to a CRAB infection. NA-E stated she was unsure where the source of the resident's infection was. On 7/21/20, at 11:31 a.m. NA-F approached NA-E and stated she would bring the mug to R1. NA-F put on gloves and an isolation gown, and entered R1's room with the mug. On 7/21/20, at 12:08 p.m. NA-G was observed carrying an empty cup and straw which was in a paper wrapper. NA-G entered the Staff Only room near the Cedar nurses' station. NA-G opened the white cooler and used a scoop to transfer ice from the cooler to the cup. NA-G then closed the cooler, placed the scoop in a holder located on, and used the faucet to fill the cup with water. NA-G exited the Staff Only room and walked to the Cedar dining room and approached R7. NA-G removed the straw from the wrapper and placed the straw in the cup. NA-G leaned towards R7, with the cup of water, and NA-G was asked to stop by the surveyor. NA-G confirmed she intended to help R7 drink water. NA-G was told the ice was contaminated from a source removed from R1's room. NA-G stated the cooler and ice needed to be removed right away. On 7/21/20, at 12:10 p.m. an interview was conducted with licensed practical nurse (LPN)-A. LPN-A stated R1 had CRAB in his urine. LPN-A stated the facility was going to change the way water was brought to residents. LPN-A was observed pushing the white cooler towards the unit elevator on a wheeled cart. On 7/22/20, at 11:31 a.m. an interview was conducted with the assistant director of nursing (ADON). The ADON stated staff contaminated themselves by removing a mug from R1's room and placing it against their scrubs. The ADON confirmed the ice was contaminated when staff touched the large plastic mug with the scoop and placed it back in the cooler. The ADON stated many other areas would had been contaminated, as well. On 7/22/20, at 1:57 p.m. an interview was conducted with the director of nursing (DON). The DON stated there was concerns for dedicated equipment, potential for transmission, and staff contamination when staff removed R1's mug from his room. The facility policy Procedure for Isolation: Initiation of Isolation Precautions undated, directed, No special precautions are needed for dishes, cups, glasses, or eating utensils. A facility policy for storing/handling ice was requested, but not provided. R1's laboratory CRAB result was requested, but not provided.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a shared bathroom was consistently cleaned when used by a resident who was identified to have a Carbapenem-resistant Acinetobacter baumannii (CRAB) infection for 3 of 4 residents (R2, R3, R4) reviewed for transmission based precautions. In addition, the facility failed to ensure routine housekeeping services were provided on the Cedar nursing unit to prevent the potential spread of multi-drug resistant organisms (MDROs). In addition, the facility failed to implement appropriate transmission based precautions for 1 of 1 residents (R1), who had a [MEDICAL CONDITION] (MRSA) infection. In addition, the facility failed to appropriately wear personal protective equipment (PPE) when in close contact with 2 residents (R8, R9) who wer placed on enhanced barrier precautions (use of gowns and gloves beyond situations in which exposure to blood and body fluids is anticipated). These practices had the potential to affect all 37 residents who resided on the Cedar nursing unit at the facility. Findings include: According to the Minnesota Department of Health (MDH) website https://www.health.state.mn.us/diseases/crab/index.html undated, Carbapenem-resistant Acinetobacter baumannii (CRAB) is a type of bacteria commonly found in the environment, especially in soil and water. CRAB can cause human infections of the blood, urinary tract, lungs, wounds, and other body sites. The bacteria are multidrug-resistant, making infections very difficult to treat. Further, Patients colonized or infected with CRAB can spread the bacteria to other patients via the contaminated hands of healthcare workers, through contaminated medical equipment, or a contaminated health care environment. Implementing infection prevention and control measures is critical to preventing CRAB transmission in health

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	07/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHRIS JENSEN HEALTH & REHABILITATION CENTER	2501 RICE LAKE ROAD DULUTH, MN 55811

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) care facilities. R2's Medical [DIAGNOSES REDACTED]. R2's quarterly Minimum Data Set ((MDS) dated [DATE], identified R2 had moderately impaired cognition. R2's MDS further identified he required extensive assistance toileting, and he needed supervision with locomotion. R2 had an ostomy (surgical opening into the abdomen to allow stool to leave the body), and was always continent of bladder. R2's care plan dated [DATE], indicated R2 had a bowel and bladder deficit related to an ostomy, and [MEDICAL CONDITION]. Interventions included offering toileting upon arising, between meals, at bedtime, and as needed. The care plan further indicated R2 independently used a urinal, was non-compliant with his [MEDICAL CONDITION] bag (pouch attached to ostomy to collect stool), and will not ask for assistance from staff. R2's care plan also identified he was placed on enhanced precautions due to a CRAB infection at his ostomy site. A progress note dated [DATE], at 4:26 p.m. indicated the facility notified R2 he tested positive for CRAB. R3's Admission Record dated [DATE], identified R3's [DIAGNOSES REDACTED]. R3's quarterly MDS dated [DATE], identified R3's BIMS score was 12 which indicated moderately impaired cognition. R3's MDS further identified he required extensive assistance toileting, was frequently incontinent of bladder, and was occasionally incontinent of bowel. R3's care plan dated [DATE], indicated R3 had a deficit with his bowel and bladder. Interventions included toilet upon arising, between meals, at bedtime, and as needed. R4's Admission Record dated [DATE], indicated R4's [DIAGNOSES REDACTED]. R4's quarterly MDS dated [DATE], identified R4 had severely impaired cognition. R4's MDS further identified he required supervision toileting, and was continent of bowel and bladder. On [DATE], at 9:05 a.m. enhanced barrier precaution signage was observed to be fixated to R2's door. A white plastic three drawer bin was outside of R2's room. The white plastic bin contained PPE supplies. R2's bathroom was shared with R3 and R4's room. R2 was observed lying in bed. An empty urinal was hanging on R2's bed rail. On [DATE], at 9:06 a.m. R2 was observed to self-propel his wheelchair to the adjoining bathroom located in his room. R2 carried a urinal which had a small amount of urine in it. At 9:09 a.m. the toilet in R2's bathroom was overheard to be flushed. At 9:12 a.m., R2 exited the bathroom in his wheelchair, with an empty urinal in his hand. On [DATE], at 9:37 a.m. an interview was conducted with nursing assistant (NA)-F. NA-F confirmed R2, R3, and R4 shared a bathroom. NA-F stated R2 did things by himself, and staff told him 100 times a day not to independently empty his ostomy. NA-F stated R2 doesn't sit on the toilet, but emptied his ostomy pouch into a graduate, and would leave it in the bathroom. NA-F stated she mopped R2's bathroom several times per day because he does not listen. NA-F stated R3 required assistance to use the bathroom, and she wiped the toilet with bleach prior to R3 using it. NA-F stated R4 independently used the adjoining bathroom, and was very confused. NA-F confirmed a risk for cross contamination existed as R2 and R4 both were known to use the shared bathroom independently and without staff knowledge. On [DATE], at 10:17 a.m. an interview was conducted with NA-H. NA-H confirmed R3 and R4 shared a bathroom with R2. NA-H stated R2's CRAB infection was at his ostomy site, and also believed R2's urine was infected. NA-H stated R2 liked to empty his ostomy pouch in the adjoining bathroom, and dumped his urine in the toilet independently. NA-H stated R2 also rinsed his coffee cup out in the bathroom sink. NA-H stated R2 played with his ostomy site, and had red spots to the area. NA-H confirmed R4 toileted himself. NA-H stated R4's cognition was good sometimes, but a lot of times he is not really with it. NA-H stated there was risk for cross contamination from time-to-time as R2 and R4 would independently use the adjoining bathroom. NA-H stated R4 would notify staff if there was a big mess in the bathroom. On [DATE], at 10:48 a.m. an interview was conducted with licensed practical nurse (LPN)-A. LPN-A confirmed R3 and R4 shared a bathroom with R2. LPN-A stated R2 had a CRAB infection at his ostomy site and was unsure if the infection was in his urine. LPN-A confirmed R2 emptied his ostomy pouch independently. LPN-A stated R4 was confused and used the bathroom independently. LPN-A stated she was unsure if nursing staff cleaned the bathrooms. LPN-A confirmed there was risk for cross contamination for R3 and R4 when they used the bathroom shared with R2. On [DATE], at 10:55 p.m. R4 was observed self-propelling his wheelchair from his room, towards the Cedar unit elevator. On [DATE], at 11:31 a.m. an interview was conducted with the assistant director of nursing (ADON). The ADON confirmed R2 played with his ostomy pouch. The ADON stated R2 was provided education, but he continued. The ADON stated she did not know if R3 or R4 used the adjoining bathroom shared with R2. On [DATE], at 1:57 p.m. an interview was conducted with the director of nursing (DON). The DON stated she believed commodes were being used for residents who had a CRAB infection and shared a bathroom with non-infected residents. The DON stated a risk for cross contamination existed if residents who had a CRAB infection used a shared a bathroom, with residents who were not infected. The DON stated she was unable to speak to why residents who had a CRAB infection shared bathrooms with those who were not infected. The DON stated she did not work at the facility when the facility was given recommendations related to the CRAB outbreak at the facility. The DON stated open beds existed at the facility at the time of the survey. On [DATE], at 2:32 p.m. an interview was conducted with the executive director and administrator. The administrator stated CRAB infections were identified at the facility in February , 2020. The administrator stated they believed a resident who had since died , acquired the infection while hospitalized . The administrator stated it was unable to be determined how other residents were infected. The executive director stated recommendations included providing private rooms to residents who had a CRAB infection. The executive director stated recommendations also included providing a commode to residents who had the CRAB infection and shared a bathroom with a resident who did not. The executive director stated a shared bathroom was supposed to be cleaned after a commode was emptied. R1's Admission Record dated [DATE], indicated R1's [DIAGNOSES REDACTED]. R1's quarterly MDS dated [DATE], identified R1 required extensive assistance with bed mobility, transfers, locomotion, and toilet use. R1's MDS further identified he had an indwelling catheter, and was frequently incontinent of bowel. R1's care plan dated [DATE], indicated R1 had a history of [REDACTED]. Staff were to adhere to enhanced barrier precautions (use of gowns and gloves beyond situations in which exposure to blood and body fluids is anticipated) to prevent infection. R10's Admission Record dated [DATE], indicated R10's [DIAGNOSES REDACTED]. R10's quarterly MDS dated [DATE], identified he required extensive assistance toileting, was always incontinent of bladder, and frequently incontinent of bowel. Facility infection surveillance documentation dated ,[DATE], indicated R1, R2, and R10 were infected with CRAB. On [DATE], at 12:10 p.m. licensed practical nurse (LPN)-A was informed a sink in the Staff Only room, located on the Cedar nursing unit, was contaminated. LPN-A stated a housekeeper was not assigned to the Cedar unit on [DATE], or [DATE]. On [DATE], at 9:37 a.m. an interview was conducted with NA-F. NA-F stated housekeeping staff was picky and chose what floor they wanted to clean. NA-F stated housekeeping staff did not want to come to the Cedar unit. NA-F stated some housekeeping staff did not go in resident rooms to sweep, mop, or clean toilets. NA-F stated some housekeeping staff looked confused, and she believed they were not well trained. On [DATE], at 10:17 a.m. an interview was conducted with NA-H. NA-H stated housekeeping staff went into resident rooms, and were supposed to clean bathrooms. NA-H stated she emptied garbages on the unit because housekeeping staff was unable to be everywhere all the time. On [DATE], at 10:33 a.m. an interview was conducted with housekeeper (H)-A. H-A stated she did not know if a housekeeper was always assigned to the Cedar unit. H-A stated the primary Cedar housekeeper was on vacation, and everyone cleaned rooms differently. H-A stated some staff only cleaned bathrooms. HSK-A stated she was trained to just protect myself when cleaning a room with a resident who had CRAB. On [DATE], at 10:48 a.m. an interview was conducted with LPN-A. LPN-A stated residents who had a CRAB infection were moved to the Cedar unit with the promise daily housekeeping would be provided. LPN-A stated housekeeping staff being assigned to the Cedar unit was hit-and-miss when the primary housekeeper was not scheduled. On [DATE], at 11:31 a.m. an interview was conducted with the ADON. The ADON stated she was not aware of any housekeeping issues on the Cedar unit. The ADON stated no staff had expressed concern about housekeeping availability. On [DATE], at 12:52 p.m. an interview was conducted with the environmental services director (ESD)-A. ESD-A stated a staff person was assigned to the Cedar unit, but was on vacation. ESD-A stated public areas and bathrooms were cleaned. ESD-A stated she had trouble with a housekeeper who worked on the Cedar unit, as they hurt their wrist, were on light duty, and later quit. ESD-A stated this devastated us a lot. ESD-A stated when a housekeeper was not scheduled on Cedar unit, other housekeeping staff were expected to clean their primary wing and do what they can on the Cedar unit. ESD-A stated residents, families, and other staff did not have complaints. ESD-A stated housekeepers had no concerns cleaning the Cedar unit due to infections that were on the unit. ESD-A stated when staff declined to be assigned to the Cedar unit, she assigned someone else. On [DATE], at 1:57 p.m. an interview was conducted with the DON. The DON stated she had concerns if housekeeping was not on the Cedar unit. The DON stated she would have liked to have had conversations with ESD-A so she knew when there was short staffing on the Cedar unit. The DON stated she did not know if additional cleaning was being completed on the Cedar unit. On [DATE], at 2:32 p.m. an interview was conducted with the executive director and administrator. The executive director stated a housekeeper assigned to the Cedar unit was on leave and was no longer employed at the facility. The administrator stated ESD-A worked the floor a lot when open shifts were identified. The facility policy Infection Prevention and Control (General) dated ,[DATE], directed, A system is in place that prevents, identified, reports, investigates, and controls infections and communicable disease for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	07/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHRIS JENSEN HEALTH & REHABILITATION CENTER	2501 RICE LAKE ROAD DULUTH, MN 55811

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement and following accepted national standards. R8's Face Sheet printed [DATE], indicated R8's [DIAGNOSES REDACTED]. R8's progress note dated [DATE], indicated R8 returned from the hospital, and was to remain on COVID-19 quarantine for 14 days, until [DATE]. On [DATE], at 9:16 a.m. R8's room was observed to have a clear bin outside of the room which included PPE, signage for enhanced barrier precaution,s and a red stop sign directing a 14 day quarantine was to be in effect until [DATE]. On [DATE], at 9:42 a.m. during continuous observation NA-A was observed entering R8's room with her face mask in place, and her eye shield resting on her chest. NA-A was observed standing next to R8's wheelchair, and talking. NA-A proceeded to clean off R8's tray table and exit room. NA-A was observed using alcohol based hand rub (ABHR) after placing R8's food tray on the cart. NA-A's face shield remained on her chest throughout the observation. On [DATE], at 9:42 a.m. NA-A verified she had entered R8's room, and had been standing right next to R8 without the face shield in place. On [DATE], at 9:46 a.m. during continuous observation, NA-A was observed entering R8's room with her face mask in place, and her eye shield still resting on her chest. NA-A was standing next to R8's wheelchair. NA-A proceeded go to R8's bathroom, gathered a pair of latex gloves and handed them to R8. NA-A then used ABHR and exited R8's room. NA-A's face shield remained on her chest throughout the observation. On [DATE], at 11:31 a.m. registered nurse (RN)-A stated staff were to be wearing eye shields while providing cares. RN-A stated all new admission were quarantined for 14 days, and staff had been instructed to don full PPE when in direct contact which included gown, eye shield/protection, and face mask. RN-A further stated it was important for staff to follow contact precautions in order to prevent spread of infection to staff and other residents. On [DATE], at 1:56 p.m. the DON stated staff were to wear the appropriate PPE while providing cares for residents. The DON stated staff were to be wearing at a minimum a face mask and eye shield protection while providing cares at all times. The DON indicated failure to don proper PPE could increase the risk of contracting or spreading COVID-19 and other related infections. The facility policy Isolation Precautions undated, directed staff to be wearing full PPE for all cares while in the facility to include eye protection for non-COVID-19 residents. R9's Face Sheet printed [DATE], indicated R10's [DIAGNOSES REDACTED]. R9's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R10 had severe impaired cognition, and required assistance with all activities of daily living (ADLs). R9's care plan initiated [DATE], indicated R9 had a bowel and bladder deficit related to indwelling catheter, and required total assistance toileting and catheter care. R9's physician orders [REDACTED]. If negative, may discontinue contact precautions and isolation. If positive, continue contact precautions/Isolation. R9's progress note dated [DATE], indicated R9 had been transferred from Spruce unit to Cedar unit. On [DATE], at 10:28 a.m. during continuous observation NA-A was observed donning PPE which included an isolation gown from another room. NA-A closed the door behind her. NA-E then entered R9's room wearing her face mask and eye shield/protection. NA-E immediately exited the room and walked across the hallway to get an isolation gown from another room. NA-E stated NA-A had told her she needed to go get a gown on since R9 required catheter care. NA-E stated isolation precaution was not indicated for R9 on the daily care sheets, nor was there signage to notify staff of the precautions. NA-E further stated she had no idea isolation precautions were required for R9. At 10:37 a.m. NA-D was observed entering R9's room wearing only her face mask and eye shield/protection. NA-D immediately exited the room, and stated NA-A and NA-E told her she should have had complete PPE in place when providing cares for R9. NA-D stated there would have been no way of knowing she was required to wear an isolation gown prior to entering R9's room, since there had not been a sign in place, nor was a PPE bin outside R9's door. On [DATE], at 10:46 a.m. LPN-A stated the facility implemented information sheets and signs on resident's doors, PPE bins, and communication group sheets to let staff know when enhanced precautions or contact precautions were required for specific residents. LPN-A stated she had received a call from hospice on [DATE], around 2:30 p.m. stating R9 required contact and enhanced precautions, related to his [DIAGNOSES REDACTED]. LPN-A verified R9's room lacked both signage and a PPE bin, both of which would have indicated to staff contact precautions or enhanced barrier precautions were required prior to entering R9's room. LPN-A stated staff would not have known he required additional precautions. On [DATE], at 3:59 p.m. the outside hospice agency staff was interviewed and verified a hospice nurse had called the facility on [DATE], with concerns that R9 was not on full precautions as ordered. The hospice supervisor also stated R9 had been on full precautions prior to his in-house transfer from the Spruce Unit to the Cedar Unit. On [DATE], at 11:31 a.m. registered nurse (RN)-A stated staff were made made aware of the residents that require isolation or precautions through the use of signage on doors, PPE bins placed outside of rooms, and group care sheets. RN-A stated staff providing cares for R9 due to his [DIAGNOSES REDACTED]. RN-A stated R9 was transferred from Spruce unit to Cedar unit on [DATE], and contact precautions were not put in place when he transferred. RN-A stated there could be the risk of and spread of infection due to lack signage, no PPE bin, and lack of information on group sheets. RN-A stated an RN manager or licensed nurse should have verified R9's orders to ensure accuracy when R9's in-house transfer occurred on [DATE]. On [DATE], at 1:56 p.m. during interview the DON verified R9 required full precautions related to [DIAGNOSES REDACTED]. The DON stated failure to implement precautions when R9 transferred to Cedar unit on [DATE], increased the risk of spreading infection. The DON stated due to lack of signage, no PPE bin, nor was this on the group sheets, staff would not have known he was on precautions. The DON stated failure to implement precautions had the potential for [MEDICAL CONDITION] to residents. The facility policy Isolation Precautions undated, directed the facility to prevent the transmission of infections within the facility through the use of Isolation Precautions. In addition to Standard Precautions, use Contact Precautions for residents known or suspected to be infected with microorganisms that can be easily transmitted by direct or indirect contact, such as handling environmental surfaces or resident-care items.