STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155106	A. BUILDING 00 B. WING	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERWALK VILLAGE	295 WESTFIELD RD NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00444592. Complaint IN00444592 - No deficiencies related to the allegations are cited. Survey dates: October 23, 24, 25, 28, 29, 30, 2024 Facility number: 000044 Provider number: 155106 AIM number: 100274940 Census Bed Type: SNF/NF: 119 Total: 119 Census Payor Type: Medicare: 3 Medicaid: 72 Other: 44 Total: 119 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed November 6, 2024.	F 0000	By submitting the enclosed Plan of Correction Riverwalk Village is not admitting to the truth or accuracy of any specific finding or allegation. We reserve the right to contest these findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. Please consider this plan of correction as our allegation of compliance. We respectfully request a desk review for this plan of correction.	
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to ensure shift-to-shift narcotic count and reconciliation was completed for 6 of 7 medication carts reviewed for medication reconciliation. (Carts HI, JI, KI, C, D, and Cottage 2)	F 0755	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *No residents were identified to be*	11/19/2024

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

Victoria Roe | Executive Director | 11/17/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Findings include: 1. During a medication storage observation of the HI medication cart, on 10/25/24 at 11:27 a.m., accompanied by LPN 7, the "Narcotic Count Sheet" was reviewed and the following dates lacked shift-to-shift count and reconciliation signatures of controlled medications: October 2024- lacked a narcotic card count: 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 11th, and 12th. October 2024- lacked shift-to-shift narcotic reconciliation signatures: 10/2: 6:00 a.m. - 2:00 p.m., 10/5: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m., 10/6: 6:00 a.m. - 2:00 p.m., 10/9: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m., 10/10: 6:00 a.m. - 2:00 p.m., 10/12: 6:00 a.m. - 2:00 p.m. and 10:00 p.m. - 6:00 a.m. 10/25: 6:00 a.m. - 2:00 p.m. During an interview, at the time of observation, LPN 7 indicated no one had signed the narcotic count for the HI cart for days shift on 10/25/24. She had been late that day and LPN 6 completed the shift to shift narcotic count with the night shift nurse prior to her arrival. She had completed a shift to shift narcotic count with LPN 6 upon her arrival but neither of them had completed the reconciliation when the HI cart was transferred from one employee to the next. The shift to shift narcotic counts and signatures were required each time the medication cart was transferred from one employee to the next. 2. During a medication storage observation of the		*affected by this alleged deficient practice. All residents received narcotic medications as ordered by doctors.* *All licensed nurses and QMAs in-serviced on Narcotic Shift to Shift count and reconciliation sheets on or before 11/19/2024* **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** *All residents receiving narcotic medications had the potential to be affected by this alleged deficient practice.* **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** *The facility Executive Director and Director of Nursing Services educated RNs/LPNs on Shift-to-Shift Narcotic Counting and the Reconciliation Forms on or before 11/19/2024. Shift to Shift Counts will be performed at the end of each shift/cart change over and the reconciliation forms will be filled out and signed by both nurses.* **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	JI medication cart, on 10/25/24 at 10:12 a.m., accompanied by LPN 8, the " Narcotic Count Sheet" was reviewed and the following dates lacked shift-to-shift count and reconciliation signatures of controlled medications: October 2024- lacked a narcotic card count: 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 21st, 22nd, 23rd, and 24th. October 2024- lacked shift-to-shift narcotic reconciliation signatures: 10/1: 10:00 p.m. - 6:00 a.m.- 2:00 p.m., 10/7: 2:00 p.m. - 10:00 p.m., 10/8: 2:00 p.m. - 10:00 p.m., 10/9: 6:00 a.m. - 2:00 p.m. 3. During a medication storage observation of the KI medication cart, on 10/25/24 at 11:42 a.m., accompanied by LPN 6, the " Narcotic Count Sheet" was reviewed and the following dates lacked shift-to-shift count and reconciliation signatures of controlled medications: October 2024- lacked a narcotic card count: 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 22nd, and 23rd. October 2024- lacked shift-to-shift narcotic reconciliation signatures: 10/1: 2:00 p.m.- 10:00 p.m. and 10:00 p.m. - 6:00 a.m., 10/2: 2:00 p.m. - 10:00 p.m., 10/4: 2:00 p.m. - 10:00 p.m., 10/5: 6:00 a.m. - 2:00 p.m., 2:00 p.m. - 10:00 p.m., 10/6: 6:00 a.m. - 2:00 p.m., 2:00 p.m. - 10:00 p.m.,		**assurance program will be put into place?** POC QAPI Tool (see attached) will be utilized by the DNS/Designee to review all narcotic sign off sheets for accuracy and completion 5 times a week for 4 weeks, 2 times a week for 4 weeks, and monthly for 4 months. Any issues will be corrected immediately and reported to the executive director. All results will be reported to the Quality Assurance and Performance Improvement Committee overseen by the facility Executive Director. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** *11/19/2024*	

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	and 10:00 p.m. - 6:00 a.m., 10/9: 2:00 p.m. - 10:00 p.m., 10/10: 6:00 a.m. - 2:00 p.m., 2:00 p.m.- 10:00 p.m., 10:00 p.m. - 6:00 a.m. During an interview, at the time of observation, LPN 6 indicated the narcotic count sheet should have been completed by both staff members when the medication cart was transferred from one staff member to another. A count should have included the number of controlled medication cards and bottles with each transfer of the medication carts. 4. During a medication storage observation of the D hall medication cart, on 10/25/24 at 12:15 p.m., accompanied by RN 3, the "Narcotic Count Sheet" sheet was reviewed and the following dates lacked shift to shift count and reconciliation signatures of controlled medications: October 2024- lacked a narcotic card count 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 11th, 12th, 13th,14th, 15th, 19th, 20th, 21st, 22nd, and 23rd. October 2024- lacked shift-to-shift narcotic reconciliation signatures 10/1: 6:00 a.m. - 2:00 p.m., 2:00 p.m. - 10:00 p.m., 10:00 p.m. - 6:00 a.m., 10/2: 6:00 a.m. - 2:00 p.m. and 10:00 p.m. - 6:00 a.m., 10/4: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m., 10/9: 2:00 p.m. - 10:00 p.m., 10/17: 10:00 p.m. - 6:00 a.m., 10/21: 6:00 a.m. - 2:00 p.m., 10/23: 6:00 a.m. - 2:00 p.m. 5. During a medication storage observation of the C hall medication cart, on 10/25/24 at 12:15 p.m., accompanied by RN 3, the "Narcotic Count Sheet"			

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	sheet was reviewed and the following dates lacked shift to shift count and reconciliation signatures of controlled medications: October 2024- lacked a narcotic card count 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 11th, 12th, 13th, 14th, 15th, 16th, 19th, 20th, 21st, 22nd, and 23rd. October 2024- lacked shift-to-shift narcotic reconciliation signatures 10/1: 2:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m., 10/2: 10:00 p.m. - 6:00 a.m., 10/6: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m., 10/7: 2:00 p.m.- 10:00 p.m. and 10:00 p.m. - 6:00 a.m., 10/8: 2:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m., 10/9: 10:00 p.m. - 6:00 a.m. During an interview, at the time of the observations, RN 3 indicated her assignment included using both carts to administer medication. The sign in/sign out sheet was to be completed by nurses at the beginning and ending of their shifts. 6. During a medication storage observation of the Cottage 2 medication cart, on 10/25/24 at 12:24 p.m., accompanied by LPN 4, the "Narcotic Count Sheet" sheet was reviewed and the following dates lacked shift to shift count and reconciliation signatures of controlled medications: October 2024- lacked a narcotic card count 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 11th,			

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	13th, 16th, 17th, 18th, and 20th. October 2024- lacked shift-to-shift narcotic reconciliation signatures 10/2: 2:00 p.m. - 10:00 p.m., 10/3: 2:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m., 10/4: 10:00 p.m. - 6:00 a.m., 10/5: 6:00 a.m. - 2:00 p.m., 2:00 p.m. - 10:00 p.m., and 10:00 p.m. - 6:00 a.m., 10/7: 10:00 p.m. - 6:00 a.m., 10/10: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m., 10/11: 6:00 a.m. - 2:00 p.m., 2:00 p.m. - 10:00 p.m., and 10:00 p.m. - 6:00 a.m., 10/12: 6:00 a.m. - 2:00 p.m. and 2:00 p.m. - 10:00 p.m., 10/24: 2:00 p.m.- 10:00 p.m. During an interview, at the time of the observations, LPN 4 indicated the sign in/sign out sheet was completed at the beginning and end of each shift to verify the narcotic count was correct. During an interview, on 10/25/24 at 1:43 p.m., the DON indicated she discovered the facility was utilizing the wrong sign in/sign out forms and changed them on October 10th. The expectation for staff was for the sheet to be filled out completely. The oncoming nurse and offgoing nurse count narcotics and sign the count sheets at the beginning and end of every shift to help prevent drug diversion. A current facility policy, revised 8/1/24, titled, "Inventory Control of Controlled Substances", provided by the DON on 10/28/24 at 1:49 p.m., indicated the following: "... Facility should ensure that the incoming and outgoing nurse count all			

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	Schedule II controlled substances and other medications with a risk of abuse or diversion at the change of each shift or at least once daily and document the results on a "Controlled Substance Count Verification/Shift Count Sheet". Facility should: Reconcile the total number of controlled medications on hand, add newly received medications to the inventory, and removed medications that are completed or discontinued from the inventory..." 3.1- 25(b)(3)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to appropriately discard expired insulin pens and label medications with resident information in 2 of 6 medication carts observed for medication storage. (D and Cottage 2) Findings include: 1. During a medication storage observation of the D hall medication cart, accompanied by RN 3, on 10/25/24 at 12:15 p.m., the following was observed: One unlabeled 8 milligram (mg) ondansetron (to prevent vomiting) blister packaged pill. One glargine (insulin) pen, with approximately 25 units remaining, with an open date of 9/20/24. During an interview, at the time of the observation, RN 3 indicated the ondansetron pill must have fallen out of the bag and the insulin was expired and should not be given to the resident.	F 0761	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *The unlabeled ondansetron blister packaged pill was removed from cart and destroyed.* *The glargine insulin pen was removed from cart and discarded.* *The unlabeled bottle of morphine was removed from the cart and destroyed.* **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** *All residents receiving medications had the potential to be affected by this alleged deficient practice.* *An audit of all medication carts*	11/19/2024

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	2. During a medication storage observation of the Cottage 2 medication cart, accompanied by LPN 4, on 10/25/24 at 12:24 p.m., the following was observed: One unlabeled bottle of morphine (a narcotic pain reliever) with approximately 14 units remaining. During an interview, at the time of the observation, LPN 4 indicated the bottle had been removed from the facility's medication management system and should have been labeled with resident information. A current facility policy, revised 8/1/24, titled, "Storage and Expiration Dating of Medications and Biologicals", provided by the Administrator on 10/29/24 at 10:46 a.m., indicated the following: "...11. Once a medication or biological package is opened, facility should follow manufacture/supplier guidelines with respect to expiration dates for opened medications...12. Facility should destroy and reorder medications and biologicals with soiled, illegible,worn, makeshift, incomplete, damaged, or missing labels..." A current facility document, dated 2022, titled, " Dating Medications & Supplies", provided by the Administrator on 10/29/24 at 11:50 a.m., indicated the following: "...Discard expired/undated medications and supplies..." 3.1-25 (j) 3.1-25 (k)		*was completed to ensure proper medication storage and dating. Any issues identified were corrected immediately.* *All licensed nurses and QMAs in-serviced on Medication Storage and Expiration Dating for Medications on or before 11/19/2024.* **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** *The facility Executive Director and Director of Nursing Services educated all RNs/LPNs on the facility policy for Medication Storage and Expiration Dating for Medications on or before 11/19/2024. All medications will be properly labelled, and any expired medications will be removed from cart and destroyed/discarded.* **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** *POC QAPI Tool (see attached) will be utilized by the DNS/Designee to review medication carts for proper medication labeling and storage in all carts 5 times a week for 4 weeks, 2 times a week for 4*	

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			weeks, and monthly for 4 months. Any issues will be corrected immediately and reported to the executive director. All results will be reported to the Quality Assurance and Performance Improvement Committee overseen by the facility Executive Director. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** *11/19/2024*	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to implement enhanced barrier precautions (EBP) during high contact care for 3 of 6 residents reviewed for infection control. (Residents 41, 2, and 79) Findings include: 1. During an observation on 10/23/24 at 11:16	F 0880	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *EBP indicators were added in resident 41's room and a banner was placed on residents chart. EBP indication was added to the*	11/19/2024

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	a.m., there was no indication of EBP outside of Resident 41's room. A Resident Matrix document, provided by the facility on 10/23/24, indicated Resident 41 had a Stage III (full-thickness skin loss, exposing fat tissue but not muscle, tendon, or bone) pressure ulcer. During an observation on 10/24/24 at 4:29 p.m., the resident was in bed on a low air loss mattress. There was no indication of EBP outside or inside the resident's room. Resident 41's clinical record was reviewed on 10/25/24 at 10:22 a.m. Diagnoses included, dementia, anorexia, unspecified severe protein-calorie malnutrition, and abnormal posture. A current physician order, dated 10/10/24, included Santyl (wound treatment) ointment 250 units per gram - cleanse open area to the sacrum with normal saline and apply Santyl to the wound bed and cover with a foam dressing. The clinical record lacked indication of enhanced barrier precautions. A quarterly Minimum Data Set (MDS) assessment, dated 9/27/24, indicated the resident was cognitively impaired. She was dependent on staff assistance for toileting, dressing, transfers, and personal hygiene. The resident had an unhealed pressure ulcer. The clinical record lacked a care plan for enhanced barrier precautions. During a wound care observation on 10/25/24 from 10:24 a.m. to 10:40 a.m. , upon entry to the		*CNA assignment sheet for resident 41. An EBP/isolation care plan was initiated for resident 41.* **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** *All residents have the potential to be affected by this alleged deficient practice.* *An audit was completed to determine all residents needing EBP had the proper indicators, orders, and care plans in place. Any issues identified were corrected immediately.* **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** *The facility Executive Director and Director of Nursing Services educated all staff on Enhanced Barrier Precautions on or before 11/19/2024. All staff will adhere to EBP policies when caring for residents indicated to need EBP.* **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** POC QAPI Tool (see attached) will be utilized by the DNS/Designee	

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	room, there was no indication of EBP inside or outside the room. LPN 6 and the ADON performed hand hygiene and donned gloves prior to the wound treatment. Gowns were not readily available for use inside the room. Both staff members walked over to the resident's right side of her bed, which was against the wall, leaned in against the resident's bed linens with their exposed clothing, and assisted the resident onto her left side for wound care on her right buttock near the sacrum. The old dressing was removed from the open right buttock wound, with scant serous drainage noted. Following wound care, LPN 6 and the ADON provided perineal care as they leaned in against the resident's bed linens with their exposed clothing. Gowns were not worn by either staff member during the course of the observation. During an interview on 10/29/24 at 11:59 a.m., CNA 11 indicated staff were required to wear a gown and gloves for high contact care activities when a resident was in enhanced barrier precautions. She was made aware when a resident was in enhanced barrier precautions by the enhanced barrier precaution signs hung outside the residents' doors. Specific precautions were also listed on the CNA assignment sheets. She indicated she was providing care for Resident 41 on this date and had not followed enhanced barrier precautions for her high contact care because the resident was not in enhanced barrier precautions. She had only worn gloves. The resident had a chronic wound, but had not been placed in enhanced barrier precautions. She knew residents with catheters required enhanced barrier precautions, but she was uncertain what other reasons a resident may need enhanced barrier precautions.		to randomly monitor staff adherence to EBP policy 5 times a week for 4 weeks, 2 times a week for 4 weeks, and monthly for 4 months. Any issues will be corrected immediately and reported to the executive director. All results will be reported to the Quality Assurance and Performance Improvement Committee overseen by the facility Executive Director. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** *11/19/2024*	

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	155106	A. BUILDING 00 B. WING	10/30/2024

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	Review of the provided CNA assignment sheet, at the time of the interview, lacked indication of enhanced barrier precautions. During an interview on 10/29/24 at 12:15 p.m., LPN 6 indicated residents with enhanced barrier precautions had a sign outside their room, above their bed, and an order in their chart for enhanced barrier precautions. Enhanced barrier precautions were required for residents with catheters, open wounds, and ostomies. Resident 41 should have had enhanced barrier precautions implemented by the Infection Preventionist, but it was not implemented. Since the sign was not present, she and the ADON had not followed enhanced barrier precautions during the resident's wound care observation and perineal care on 10/25/24. She should have known to follow enhanced barrier precautions, even though signs were not posted, since the resident had an open wound. A gown and gloves were required during the resident's high-contact care. During an interview on 10/29/24 at 12:31 p.m., the ADON indicated enhanced barrier precautions should have been previously initiated when the resident's open wound was identified.2. Resident 2's clinical record was reviewed on 10/25/24 at 9:30 a.m. Diagnosis included spastic quadriplegic cerebral palsy, unspecified severe protein-calorie malnutrition, oropharyngeal dysphagia, and epilepsy. A physician's order, dated 5/17/24, indicated may crush appropriate medications and administer per gastrostomy tube. Check placement of gastrostomy tube and check residuals (fluid or contents in the stomach). A physician's order, dated 6/4/24, indicated			

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	enteral feeding (to provide nutrition), gastrostomy tube, size 18 French (diameter of the tube). An isolation care plan, dated 6/10/24, indicated the resident was at risk of transferring Multidrug-Resistant Organisms (MDROs) and required enhanced barrier precautions related to indwelling medical devices. The approaches included to use standard precautions including hand hygiene and to wear gown and gloves for high-contact resident care activities. During an observation, on 10/23/24 at 9:50 a.m., Resident 2's room had an Enhanced Barrier Precautions sign on the wall directly beside the door. Personal protective equipment (PPE) was in a plastic container directly below the sign. Resident 2 was lying in bed with an enteral tube pump at bedside. During a medication administration observation, on 10/25/24 at 8:21 a.m., RN 3 crushed medications for Resident 2. RN 3 donned gloves and lifted the resident's gown to access the gastrostomy tube to her left abdomen and completed the medication administration. During an interview, on 10/25/24 at 8:51 a.m., RN 3 indicated Resident 2 was in enhanced barrier precautions and she had forgotten to don a gown while providing care to her gastrostomy tube. The enhanced barrier precaution required staff to wear protection when working with resident that have catheters, gastrostomy tubes and wounds or openings in the skin to prevent the spread of infection. 3. Resident 79's clinical record was reviewed on 10/28/24 at 10:08 a.m. Diagnosis included malignant neoplasm of the prostate, type 2			

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	diabetes mellitus, benign prostatic hyperplasia, and a stage 3 (full thickness tissue loss) pressure ulcer to left heel. A physician's order, dated 10/22/24, indicated cleanse left heel wound with Dakin's (an antiseptic) solution, apply Hydrofera Blue (to treat bacteria and protect) to wound bed every 3 days on day shift and as needed. An isolation care plan, dated 4/17/24, indicated Resident 79 was at risk of transferring MDRO's and required enhanced barrier precautions related chronic wounds requiring a dressing. The approaches included to use standard precautions including hand hygiene and to wear gown and gloves for high contact resident care activities. During a wound care observation, on 10/28/24 at 9:47 a.m., Resident 79 was lying in bed. An enhanced barrier precautions sign was taped to the wall at the foot of his bed. His bed was against the wall horizontally. Two nursing staff members performed hand hygiene and donned gloves. The Unit Manager set up a sterile field on the bedside table. LPN 6 was assisting by holding the residents left leg up at the ankle. The Unit Manager removed the bandage to the resident's left leg. The open wound was approximately the size of a quarter. The Unit Manager performed wound care while LPN 6 held the resident's leg. The Unit Manager gathered the used supplies and trash to dispose of and performed hand hygiene. During an interview, at the time of the observation, LPN 6 and the Unit Manager both indicated Resident 79 was on enhanced barrier precautions for his open wound and they had both forgotten to don a gown prior to beginning his wound care treatment. LPN 6 indicated			

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	enhanced barrier precautions were to be worn when working with residents that have catheters, feeding tubes, and open wounds. During an interview, on 10/30/24 at 1:51 p.m., the DON indicated it was the expectation for staff to follow all the guideline for enhanced barrier precautions. These precautions assist in preventing the spread of infections. The residents who required enhanced barrier precautions had catheters, feeding tubes, MDRO's, and open wounds requiring a dressing. During an interview, on 10/30/24 at 2:25 p.m., the Infection Preventionist indicated staff were expected to understand the enhanced barrier precautions protocols. She placed signs and PPE at the residents' rooms that required enhanced barrier precautions. All staff should have worn PPE when providing care for an open wound or giving medications through a gastrostomy tube. A current facility policy, revised 4/24/24, titled, "Standard Precautions and Transmission- Based Precautions (Isolation) Policy", provided by the DON on 10/28/24 at 1:49 p.m., indicated the following: "...Enhanced Barrier Precautions (EBP): An intervention designed to reduce the transmission of resistant organisms that employs targeted use of gown and glove use during high contact resident care activities. EBP expands the use of PPE beyond situations in which exposure to blood and body fluids is anticipated, it refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Enhanced barrier precautions are used for: Resident(s) with chronic wounds and/or indwelling medical devices, regardless of their MDRO status...Wounds generally			

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	include...pressure ulcers... Indwelling medical device examples include...feeding tubes..." 3.1-18(l)			