STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155328	A. BUILDING 00 B. WING	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PARK TERRACE VILLAGE	25 S BOEHNE CAMP RD EVANSVILLE, IN 47712

(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. Survey dates: March 3, 4, 5, 6, 7, and 10, 2025 Facility number: 000221 Provider number: 155328 AIM number: 100267620 Census Bed Type: SNF/NF: 60 Total: 60 Census Payor Type: Medicare: 3 Medicaid: 48 Other: 9 Total: 60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 18, 2025.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of the Post Survey Revisit.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, interview, and record review, the facility failed to ensure a resident was treated with dignity during a meal observation for 1 of 1 resident's reviewed for activities of daily living who required staff assistance to eat. (Resident 3) Finding includes: During an interview on 3/4/25 at 10:04 A.M., a	F 0550	It is the policy of the facility to treat each resident with respect and dignity and care for each resident in the manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. It is the policy of the facility to protect and promote the	04/09/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Claudia Schmitt	Administrator	03/28/2025

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	family member indicated Resident 3 is not able to feed herself, and staff not always willing to assist her with eating. On 3/5/25 at 10:20 A.M., Resident 3's clinical record was reviewed. Resident 3's diagnoses included, but were not limited to, hypertensive heart disease and congestive heart failure (CHF). The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 2/15/25, indicated Resident 3 was severely cognitively impaired and was dependant on staff (staff do all of the work) for eating, toileting, showering, and transfers, and received oxygen therapy. Current care plans included, but were not limited to: Resident requires assistance with ADLs (activities of daily living) including bed mobility, transfers, eating and toileting related to: weakness, decreased mobility, incontinence, impaired cognition, Start date 6/22/22 During an observation on 3/5/25 at 12:24 P.M., CNA 5 indicated all lunch trays had been passed. Resident 3's lunch tray was sitting on her bedside table next to her, out of her reach, and staff were not feeding Resident 3. At 12:51 P.M., CNA 9 yelled down the hall to CNA 5, who was removing the lunch tray from Resident 3's room, and asked CNA 5 if Resident 3 still needed to be fed. CNA 5 stated she had forgot, and entered Resident 3's room to assist with feeding her. During an interview on 3/10/25 at 11:26 A.M., The Administrator indicated the facility did not have a written policy related to dignity but the facility's policy was to treat all residents with dignity and respect.		rights of the residents. **•What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** -Resident #3 is being treated with respect and dignity. Resident #3 is being assisted with eating for all meals. Resident #3 profile was updated. **•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 the alleged deficient practice. -All nursing staff will be educated by DNS/designee on identification of residents requiring assist with meals, and ensuring that when meals are served, a staff member begins assisting resident with eating at time of serving. **•What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** -CNA #9 and CNA #5 were educated on assisting residents with meals timely -Daily rounds will be completed by meal manager/designee to ensure all residents who require	

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	3.1-3(t)		assist with meals are being assisted timely. **•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** -The DNS/designee will be responsible for the completion of the Resident Rights QAPI Tool weekly x4 weeks, monthly x6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If company threshold is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, interview, and record review, the facility failed to ensure residents that were self administering medications were assessed for capability to self administer medications for 1 of 1 residents observed with medications in their room. (Resident 8) Finding includes: On 3/4/25 at 10:04 A.M., a white pill and a red pill were observed in a medication cup on Resident 8's	F 0554	**It is the policy of the facility to allow residents to self-administer medications when deemed safe and appropriate by the IDT team.** **•What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** -Resident #8 was assessed and	04/09/2025

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	bedside table. On 3/5/25 at 12:25 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, type 2 diabetes mellitus and major depressive disorder. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 1/16/25, indicated Resident 8 was cognitively intact, was dependent on staff for rolling left to right, toileting, and bathing, and received antianxiety medication, antidepressants, hypnotics, anticoagulants, diuretics, opioids, and hypoglycemic medications during the seven day look back period (1/10/25 to 1/16/25). The clinical record lacked an assessment, order, and care plan related to the resident's ability to self administer medications. On 3/6/25 at 1:19 P.M., Qualified Medication Aide (QMA) 14 indicated there were no residents who were allowed to self administer their own oral medications. On 3/6/25 at 2:02 P.M., the Administrator indicated that Resident 8 did not have a self administration of medication assessment or order. On 3/10/25 at 11:00 A.M., the Administrator provided a current Self Administration of Medication policy, dated 11/2015, that indicated "Periodic evaluations of the resident's ability to self-administer medications must be made to ensure that safe and effective procedures are followed". 3.1-11(a)		reviewed for self-administration. Nurse Practioner reviewed medications as well due to resident desire to eliminate the number of medications. Resident is not self-administering medications at this time. **•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 the alleged deficient practices. -All residents will be reviewed to determine if they want or qualify for the need to self-administer medications. -Nurses and QMAs will be educated that only residents with orders to self-administer medications can have medications left at bedside. **•What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** -Daily rounds will be completed daily by DNS/designee to ensure no medications are left at bedside unless resident has order for self-administration of medication order. **•How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place -The DNS/designee will be responsible for the completion of the self-administration of medication QAPI Tool weekly x4 weeks, monthly x6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If company threshold is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview, and record review, the facility failed to ensure respiratory services were provided according to professional standards for 3 of 3 residents reviewed for respiratory care. Residents were receiving oxygen at a flow rate that was not consistent with the physician order.(Resident 8, Resident 3, Resident 47) Findings include: 1. On 3/4/25 at 10:10 A.M., Resident 8 was observed lying in bed receiving 4 liters (L) of oxygen via nasal cannula. At that time, Resident 8 indicated she was supposed to receive 3 L of oxygen.	F 0695	**It is the policy of the facility provide respiratory care consistent with professional standards of practice, the comprehensive person-centered care plan, and per the residents' goals and preferences.** **•What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** -Resident #8, resident #3 and resident #47 are receiving oxygen therapy per physician orders. **•How other residents having**	04/09/2025

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	On 3/5/25 at 12:35 P.M., Resident 8 was observed lying in bed receiving 4 L of oxygen via nasal cannula. On 3/6/25 at 1:18 P.M., Resident 8 was observed lying in bed receiving 4 L of oxygen via nasal cannula. On 3/5/25 at 12:25 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD). The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 1/16/25, indicated Resident 8 was cognitively intact, was dependent on staff to roll left and right, toileting, and bathing, and was receiving oxygen therapy. Current physician orders included, but were not limited to: Oxygen at 2 liters per nasal cannula every shift, dated 1/10/25 A current risk for impaired gas exchange care plan, revised 1/20/25, included an intervention of oxygen at 2 L per nasal cannula. On 3/6/25 at 1:20 P.M., Qualified Medication Aide (QMA) 14 indicated that Resident 8 was supposed to be on 2 to 3 liters of oxygen.2. During an observation on 3/4/25 at 1:40 P.M., Resident 3 was observed laying in bed. Her nasal cannula was not in her nose and the tubing was hanging on one ear. Resident 3's oxygen concentrator was on 1 liter. On 3/5/25 at 10:20 A.M., Resident 3's clinical record was reviewed. Resident 3's diagnoses included, but were not limited to, hypertensive		**the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** -All residents who wear oxygen have potential to be affected by the alleged deficient practice. -All residents with an order for oxygen will be audited to ensure they are using the correct liter of oxygen per physician order. -All nurses will be educated on checking and ensuring residents who wear oxygen are on the correct liter flow rate per physician order. -QMA#14 received 1 on 1 education regarding looking at physician orders for oxygen flow rate and notifying nurse if changes are needed. **•What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** -Daily rounds will be completed by the DNS/designee to ensure the residents who wear oxygen are using the appropriate liter flow per physician order. **•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** -The DNS/designee will be responsible for the completion of	

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	heart disease and congestive heart failure (CHF). The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 2/15/25, indicated Resident 3 was severely cognitively impaired and was dependent on staff (staff do all of the work) for eating, toileting, showering, and transfers, and received oxygen therapy. Current physician orders included, but were not limited to: Oxygen at 2 liters per nasal cannula every shift, start date 4/10/23 The current care plan included, but was not limited to: Resident has potential for impaired gas exchange related to: CHF, utilizes supplemental O2 (oxygen), Start date 1/17/24 Administer oxygen as ordered - 2 liters per nasal cannula, Start date 1/17/24 3. During an observation on 3/4/25 at 2:24 P.M., Resident 47's oxygen concentrator was on four liters. Resident 47 indicated she should be receiving 2 liters of oxygen. On 3/6/25 at 9:09 A.M., Resident 47's clinical record was reviewed. Resident 47's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD). The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 2/13/25, indicated Resident 3 was dependent on staff (staff do all of the work) for transfers, and received oxygen therapy. Current physician orders included, but were not		the respiratory care QAPI Tool weekly x4 weeks, monthly x6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If company threshold is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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	limited to: Oxygen at 2 liters per nasal cannula every shift, start date 1/8/25 The current care plan included, but was not limited to: Resident has potential for impaired gas exchange related to COPD, Start date 5/10/24 Administer oxygen as ordered - 2 liters per nasal cannula, Start date 5/10/24 During an interview on 3/7/25 at 8:48 A.M.,Licensed Practical Nurse (LPN) 10 indicated Resident 47 should be receiving 2 liters of oxygen. On 3/10/25 at 11:00 A.M., the Administrator provided a current Oxygen Therapy policy, dated 11/2015, that indicated "The nurse will coordinate the oxygen therapy services as ordered by the resident's physician". 3.1-47(a)(6)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, record review, and interview, the facility failed to ensure proper storage of and labeling of medications for 3 of 5 medication carts and 1 of 2 wound treatment carts. Loose pills, food, and unlabeled medications were observed in the medication and treatment cart drawers. (Treatment Cart for B Hall, A Hall Medication Cart, B Hall Medication Cart, C Hall Medication Cart) Findings include: 1. On 3/4/25 at 10:49 A.M., the Treatment Cart for	F 0761	**It is the policy of the facility to label and store drugs and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.** **•What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	04/09/2025

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	the B Hall was observed with the following: 1 bottle of Peri cleaner(cleaner) without label or resident name 1 can of soda in the third drawer in the third drawer 1 pair of toenail clippers no resident name or storage bag 2. On 3/4/25 at 11:00 A.M., the B Hall Medication Cart was observed to have an open package of chewing gum without identification of ownership. 3. On 3/4/25 at 11:15 A.M., the A Hall Medication Cart was observed with the following: 1 small round pill with the number 11 1 small round orange pill with the letter F and the number 50 1 bottle of Acetaminophen (pain medication) 500 milligrams (Mg) without label or open date. 4. On 3/4/25 at 11:26 A.M., the C Hall Medication Care was observed with 2 loose Cephalothin (Antibiotic) pills in a drawer. 5. On 3/6/25 at 7:19 A.M., during a medication pass to Resident 28, Qualified Medication Aide (QMA) 14 was observed dropping a pill on the top of the B Hall Medication Cart and placed into a medicine cup that was later given to the resident. QMA 14 observed passing medications to Resident 19 who refused a stool softener pill and placed the pill in a cup and left it unlabeled in a medication drawer. During an interview on 3/4/25 at 10:55 A.M., the Assistant Director of Nursing (ADON) indicated if it comes in a bottle there should be a label. ADON also indicated there should be no food or nail		**practice;** -Resident #28's and Resident #19's medications are being stored appropriately. -The identified bottle of peri cleaner, soda, toe nail clipper, chewing gum were removed from the cart. -The identified round pill, orange pill, acetaminophen, antibiotic pills, and stool softener pill were 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 have the potential to be affected by this alleged deficient practice. -All nurses and QMAs will be educated on medication storage and labeling. -QMA #14 will receive 1 on 1 education regarding medication storage and labeling. -All medication carts, treatment carts and medication rooms were audited to ensure medications are being stored appropriately. **•What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** -DNS/designee will complete daily audits of medication and treatment carts to ensure appropriate storage and labels are	

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	clippers in the treatment or medication carts. The nail clippers should be in a plastic bag and labeled. During an interview 3/7/25 at 11:15 A.M., the Director of Nursing (DON) indicated that if a QMA drops medication it should be thrown away and a new one to replace it. If a resident refuses a medication it is to be thrown away and not left in a drawer unlabeled. Medications should be labeled with the name of the resident if put in a cup locked drawer. On 3/10/25 at 11:00 A.M., the Administrator provided a current policy "Medication Storage and Expiration Policy dated 11/24. The policy indicated "...food is not to be stored in... general storage areas where medications are stored...facility should destroy and reorder medications when...damaged...should be stored in accordance with manufacturers' recommendations. 3.1-25(k)(1) 3.1-25(o) 3.1-18(b)		in place. **•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** -The DNS/designee will be responsible for the completion of the medication storage QAPI Tool weekly x4 weeks, monthly x6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If company threshold is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to safely store and produce food under professional standards related to food items not labeled or stored properly and sanitary kitchen surfaces for 1 of 1 dietary areas observed. Findings include: During a kitchen walk through on 3/4/25 at 9:03 A.M., the following was observed:	F 0812	**It is the policy of the facility to store, prepare, distribute and serve food in accordance with professional standards for food service safety.** **•What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** -No residents were identified	04/09/2025

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	Walk in refrigerator: One pitcher labeled sweet tea, no date One pitcher labeled apple juice, dated 2/28 use by 3/1 One opened bag and two closed bags of wilting lettuce, best by date 2/23/25 Bag of sliced American cheese, opened 2/26 use 3/4 Bag of shredded cheese, opened 2/26 use 3/4 Bag of mozzarella cheese open to air, opened 2/24 use by 3/3 Walk in freezer: Bag of Canadian bacon, dated 2/6 use by 2/9 Bag of meatballs, dated 2/20 Dry storage: Box of loaves of bread directly on floor Opened bag of instant mashed potatoes, no date Opened of penne pasta, dated 1/18 Opened of macaroni noodles, no date Opened bag of egg noodles, no date Opened bag of zita rigate noodles, no date Box of powdered sugar, open to air Box of puree rice mix, open to air		-The identified pitcher of sweet tea, apple juice, lettuce, shredded cheese, Canadian bacon, meatballs, loaves of bread, instant mashed potatoes, penne pasta, macaroni noodles, egg noodles, zita rigate noodles, powdered sugar, puree rice mix were destroyed -The identified scoop , stove and top of stove, was thoroughly cleaned **•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 the alleged deficient practice. -All food items with no date or past expiration date were discarded including sweet tea, apple juice, bags of lettuce, American cheese, shredded cheese, mozzarella cheese, Canadian bacon, bag of meatballs, penne pasta, macaroni noodles, egg noodles, zita noodles, powdered sugar, rice mix. -Food items are not being stored in boxes on the floor. -Floor around the stove and stove topped were cleaned. -Walk through area, dry storage area was inspected to ensure all food was appropriately labeled, or discarded if outdated. The kitchen was thoroughly cleaned by dietary	

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	Black handled scoop with residue sitting directly on open shelf Floor around stove and top of stove dirty with food debris On 3/7/25 at 9:37 A.M., the Dietitian indicated food should be labeled and dated according to the facility policy. On 3/10/25 at 11:00 A.M., the Administrator provided a policy titled Food Storage, revised 5/23, that indicated "4. Scoops should be kept covered in a protected area near the containers. 6. Food is stored a minimum 6" above the floor. 7. Leftover prepared foods and processed meats are to be stored in covered containers and wrapped securely. The food must be clearly labeled and dated with the name of the product, the date it was prepared, and marked to indicate the date by which the food shall be consumed or discarded. Leftover foods can be held at 41 Fahrenheit (F) or less for no more than 3 days. The day the food was prepared shall be counted as day 1. 8. Refrigerated, ready to eat, potentially hazardous food purchased from approved vendors shall be clearly marked with the date the original container is opened and the date by which the food shall be consumed or discarded. This opened food can be held at 41 F or less for no more than 7 days and the date marked may not exceed the manufacturer's use by date. 13. Dry storage containers with covers must be used for storing flour, sugar, pasta.. and partial cases of bulk foods when removed from their original container. These containers should be labeled and dated on both the container and lid. All food shall be covered or wrapped tightly, labeled, and dated. 3.1-21(i)(3)		manager/designee **•What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** -Kitchen staff will be educated by the Culinary manager/designee regarding food storage and labeling. -Culinary Manager/designee will complete daily rounds to ensure food items are labeled and stored appropriately and to ensure cleanliness of the kitchen. **•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** -The culinary manager/designee will be responsible for the completion of the food storage QAPI Tool weekly x4 weeks, monthly x6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If company threshold is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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	155328	A. BUILDING 00 B. WING	03/10/2025

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F 0880 SS=E Bldg. 00	3.1-21(I)(2) 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure infection control practices and standards were performed during 3 of 3 random observations. Staff observed not performing hand hygiene during a medication pass of B Hall, using Enhanced Barrier Protection (EBP), and changing gloves during care. (Resident 28, Resident 39, Resident 19, Resident 48, Resident 41, Resident 18, Resident 22, Resident 3) Findings include: 1. On 3/6/25 at 7:19 A.M., during a random observation of a medication pass, Qualified Medication Aide (QMA) 14 failed to perform hand sanitization prior to entering Resident 28's room. On 3/6/25 at 7:25 A.M., during a random observation of a medication pass, QMA 14 failed to perform hand hygiene prior to entering and exiting Resident 39's room. On 3/6/25 at 7:32 A.M., during a random observation of a medication pass, QMA 14 failed to perform hand hygiene prior to entering and exiting Resident 19's room. On 3/6/25 at 7:38 A.M., during a same random observation of a medication pass, QMA 14 sneezed into sleeve without performing hand hygiene and exiting Resident 48's room. On 3/6/25 at 7:45 A.M., during a random	F 0880	**It is the policy of the facility to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.** **•What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** -Resident #28, #39, #19, #48, #41, #18, #22, and resident #3 were assessed with no effects noted related to alleged deficient practice. -QMA#14, CNA # 6 and CNA #7 were educated by infection preventionist regarding infection control practices including hand hygiene policy **•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 the alleged deficient practice. -QMA#14, CNA # 6 and CNA #7 were educated by infection preventionist regarding infection control practices including hand	04/09/2025

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	observation of a medication pass, QMA 14 failed to perform hand hygiene prior to entering and exiting Resident 41's room. On 3/6/25 at 7:50 A.M., during a random observation of a medication pass, QMA 14 failed to perform hand hygiene prior to entering Resident 18's room. During an interview on 3/7/25 at 11:01 A.M., the Infection Preventionist indicated staff should perform hand hygiene before they touch anything, before going into a resident's room, and after leaving the resident. 2. On 3/7/25 at 8:39 A.M., Certified Nurse Aide (CNA) 6 was observed performing incontinence care for Resident 22. CNA 6 was not wearing a gown. An Enhanced Barrier Precaution (EBP) sign was observed above Resident 22's bed. The sign indicated that staff should wear a gown and gloves during high contact care. On 3/7/25 at 9:25 A.M., Resident 22's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and stage two pressure ulcer. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 2/17/25, indicated Resident 22 had severe cognitive impairment, was dependent on staff for toileting, and did not have a pressure ulcer. Current care plans included, but were not limited to: Resident is at risk of transferring or becoming colonized with an Multi-Drug Resistant Organizisms (MDRO) and requires enhanced barrier precautions due to a chronic wound that requires a dressing, dated 3/5/25		hygiene policy. -All staff will be educated on infection control practices, including hand hygiene and enhanced barrier policy. **•What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** -The infection preventionist/designee will complete daily rounds to ensure appropriate infection control techniques are utilized. The Infection preventionist/designee will complete skills validations on hand hygiene as well as PPE use skills validations. **•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** -The IP/designee will be responsible for the completion of the infection prevention QAPI Tool weekly x4 weeks, monthly x6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If company threshold is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including	

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	A Wound Management Observation note, dated 3/5/25 at 10:30 A.M., indicated Resident 22 had a stage two pressure ulcer on the right side of her sacrum. On 3/7/25 at 10:22 A.M., the Director of Nursing (DON) provided a current list of residents who were on EBP. Resident 22 was listed. On 3/7/25 at 10:39 A.M., the Director of Nursing (DON) indicated that residents on EBP had a care plan for EBP, but did not have physician orders for EBP. On 3/7/25 at 11:01 A.M., the IP indicated that if a resident was on EBP, staff should wear gown and gloves during high contact care. 3. During an observation of incontinence care on 3/7/25 at 11:26 A.M., CNA 7 entered Resident 3's room, sanitized her hands, and put a gown and gloves on. CNA 7 raised Resident 3's bed with the remote, rolled Resident 3 to her side, and removed her pants and soiled brief. CNA 7 used incontinence wipes to clean Resident 3. CNA 7 removed her gloves, applied hand sanitizer, put new gloves on, and put a clean brief under Resident 3. CNA 7 looked through Resident 3's dresser and bedside table drawers with gloves on to find barrier cream. CNA 7 applied barrier cream on Resident 3's bottom, wiping the cream over the wounds on Resident 3's coccyx and left gluteal fold. CNA 7 removed her soiled glove, put a new glove on, and rolled Resident 3 back over and assisted pulling her brief and pants up. On 3/10/25 at 11:00 A.M., the Administrator provided a current policy " Hand Hygiene Policy" revised in 12/21. The policy indicated "...hand hygiene applies to hand washing, antiseptic hand		termination of responsible employee.	

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	wash, and alcohol based hand rub...moments of hand hygiene include...before touching a patient, after body fluid risk, and after touching a resident..." On 3/10/25 at 11:00 A.M., the Administrator provided a current undated Enhanced Barrier Precautions policy that indicated "Use of personal protective equipment - gown and gloves - during high-contact resident care activities...changing briefs or assisting with toileting... Gloves and gown prior to the high-contact care activity...". 3.1-18(b)(2) 3.1-18(l)			