STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045147	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookridge Cove Rehabilitation and Care Center	1000 Brookridge Lane Morrilton, AR 72110

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on facility document review, interviews, record review, and facility policy review, it was determined that the facility failed to ensure sufficient staffing to meet the residents' needs as evidenced by not following the facility assessment staffing guidelines for 15 of 15 shifts reviewed from 01/04/2025 day shift through 03/06/2025 night shift. The findings include: The Facility Assessment indicated the facility acuities affecting licensed nurses included cancer treatments, respiratory treatments, behavioral and mental health, medication management, high risk of intravenous or intramuscular medications and infusions, dialysis care which was contracted with an outside vendor, ostomy care, hospice care also contracted with an outside vendor, respite care, isolation precautions/education/monitoring, wound care, tube feedings/parenteral nutrition and drain/tube management. The Facility Assessment indicated the facility acuities affecting nurse aides indicated assistance provided with dressing 90%, assistance provided with bathing 100%, assistance provided with transfers 90%, assistance provided with eating 95%, assistance provided with toileting 90-95%, assistance provided with mobility 70-75% with varying times and distances, assistance provided with splints/braces 25-30 residents, assistance provided with behavioral symptoms, 50% of the population. The facility assessed their coverage needs to adequately meet the residents' daily needs per shift as: Registered Nurses (RN): - Director Of Nursing (DON): One RN full-time, 5 days a week; Assistant Director of Nursing (ADON): two RNs full-time, 5 days a week; Minimum Data Set (MDS) Coordinator: 5 days a week; Other RN: 5 days a week. Days may vary, to include at least one full-time RN every day. Overall staffing coverage needed for RNs per day equaled eight hours per day. Licensed Nurses and Certified Nursing Assistants (CNAs): The following staff recommendations were indicated for licensed nurses and CNAs: For a census of 95 to 99, day shift required 18, evening shift required 11 to 12, and night shift required 8. For a census of 101 to 103, day shift required 18-19, evening shift required 11 to 12, and night shift required 8. (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	For a census of 106 or greater, day shift required 20 to 21, evening shift required 15, and night shift required 10 to 11. A review of documents titled Time Punch Sheets for January 2025 through March 2025 daily staffing was reviewed from the employee's time clock punch reports starting with the day shift on 01/04/2025 on specific dates through the end of the night shift on 03/06/2025. Using staffing guidelines defined by the facility in their 05/26/2025 Facility Assessment the bedside staff coverage was found lacking coverage by either a partial or complete shift on the following days: 02/01/2025 Day Shift: 1 RN worked 9:03AM-3:00 PM; 2 LPNs; 13 CNAs. Per facility assessment with a census of 106+ Day Shift should have 5-6 LPNs, 15 CNAs. Evening Shift: 2 RNs (1 RN worked 3:00 PM-7:00 PM);1 LPN; 12 CNAs (1 CNA worked 3:00 PM – 7:00 PM). Per facility assessment with a census of 106+ Evening Shift should have 4 LPNs and 11 CNAs. Nights Shift: 1RN; 2 LPN; 7 CNAs. Per facility assessment with a census of 106+ Night Shift should have 2-3 LPNs and 8 CNAs. 02/02/2025 Day Shift:1 RN hours worked 9:00AM-3:00 PM; 2 LPNs; 14 CNAs (1 CNA worked 8:00 AM-3:00 PM.) Per facility assessment with a census of 106+ Day Shift should have 5-6 LPNs and 15 CNAs. Evening Shift:2 RNs, 1RN worked 3:00 PM-7:00 PM; 1 LPN; 12 CNAs (1 CNA worked 3:00 PM – 7:00 PM). Per facility assessment with a census of 106+ Evening Shift should have 4 LPNs and 11 CNAs. Night Shift: 1 RN; 2 LPNs; 7 CNAs. Per facility assessment with a census of 106+ Night Shift should have 2-3 LPNs and 8 CNAs. 02/15/2025 Day Shift- 1 RN worked 9:30AM-3:00 PM; 2 LPNs; 10 CNAs (1 CNA worked 7:00 AM-11:00 AM). Per facility assessment with a census of 106+ Day Shift-should have 5-6 LPNs and 15 CNAs. Evening Shift: 2 RNs (1 RN worked 3:00 PM-6:30 PM); 2 LPNs (1 LPN worked 3:00 PM-7:00 PM); 10 CNAs (1 CNA worked 3:00 PM-7:00 PM). Per facility assessment with a census of 106+ Evening Shift should have 4 LPNs and 11 CNAs. Night Shift: No RNs worked this shift; 2 LPNs; 6 CNAs. Per facility assessment with a census of 106+ Night Shift should have 2-3 LPNs and 8 CNAs. 02/16/2025 Day Shift: 1 RN worked 9:45AM-3:00 PM;1 LPN; 13 CNAs (1 CNA worked 7:00 AM-10:45 AM). Per facility assessment with a census of 106+ Day Shift should have 5-6 LPNs and 15 CNAs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and observation on 07/28/2025 at 1:00 PM, Resident #97 stated they used a urinal and wore a brief. This surveyor observed two half-full urinals sitting on the bedside table which left a strong, foul odor in the room and outside in the hall. The resident stated the facility had been short-staffed, which affected the care they provided. Resident #97 stated it took too long, and being dependent on staff for everything made it hard sometimes. Resident #97 revealed the longest time they had to wait for staff to change their brief was four hours. During an interview on 07/30/2025 at 10:49 AM, Resident #32's family member stated, the facility was always short staffed and always made excuses. Resident #32's family member also indicated facility staff left the resident lying in a urine-soaked bed with a full diaper. Resident #32's family member stated staff changed the brief but left the bed soaking wet. The family member reported they checked that when they first arrived. The family member had mentioned to the nurses how soaked the bed was and was told, if you get the resident up to a chair, we will change the linens. Resident #32's family member stated they spoke to the DON about the resident lying in a dirty brief for two hours on urine soaked linens. The family member revealed staff stated they would change the resident when it was the residents' turn. The family member stated, the facility did not have enough staff during all shifts and the ones [staff] they did have did not care. During an interview on 07/30/2025 at 1:49 PM, CNA #12 stated all residents' positions should be changed every two hours or as needed. She stated she frequently started the shift with residents in a dry brief and soaked bed. The residents that could talk would tell staff they were cold, and needed a blanket, or were dirty due to being left in a soaked bed. CNA #12 stated, The staff during Monday through Friday night shift does not know how to place a diaper on correctly. CNA #12 stated it was harder on the day shift staff to clean all the residents, due to being frequently short staffed. During an interview on 07/30/2025 at 3:06 PM, LPN #9 stated there had been residents with dry briefs on, left with soaking wet bed linens. I see it more than I should. We are short staffed at times. During an interview on 07/30/2025 at 6:24 PM, Resident #111's family member revealed staff always stated they were short staffed or would say other staff were supposed to come in but had not shown up to work, therefore they were not able to get to the residents timely. During an interview on 07/31/2025 at 11:18 AM, CNA #14 revealed there were some halls where the call lights would go off for a long period of time, and some of us staff frequently leave our hall to help the residents on other halls, so there would not be an incident of a resident getting hurt or skin breakdown. CNA #14 stated there were times when the staff would be so busy, due to being short staffed that they would not have time to complete all their required assignments or tasks for that shift. CNA #14 also revealed staff were frequently asked to stay over to cover a call in or to work an extra shift due to being short staffed. During an interview on 07/31/2025 at 11:42 AM, CNA #15 stated there have been a few times baths were not given to the residents, due to not having enough staff. CNA #15 stated, You can only do so much. CNA #15 did not specify which shift but stated that weekends were always low staffed due to employees not wanting to work. CNA #15 revealed the task they had a hard time completing was changing the residents' briefs during the last round. CNA #15 stated they were asked to stay late, work over, or come in early to help due to call ins on a regular basis. During an interview on 07/31/2025 at 2:29 PM, the DON defined direct care staff as staff that provided direct care to the residents, and the staffing matrix was defined as the number of staff used (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to provide care to the residents. The DON revealed that to determine the staffing levels needed to meet residents needs each day and during emergencies, the Administrator met annually with the DON, the ADONs and the Regional [NAME] President (RVP) to review the halls, the census, and what licensed staff were needed. She reported they would review what type of residents were on the halls, and how they assigned staff to a hall according to the residents' care. The DON revealed there were times staff had talked to her about workload concerns, and she stated she reassured them adjustments would be made. The DON stated the workload was adjusted, time management skills were reviewed, and she made changes to the system. The DON reported in the last six months; the facility had experienced low staffing. She also reported some residents had been wet at shift change but did not have adverse effects from these incidents. During an interview on 07/31/2025 at 4:59 PM, the Administrator verified direct care staff as someone that had a certification or license and took direct care of the residents. The Administrator reported they have had grievances on staff starting their shift with residents that had wet briefs and wet linens from not being changed. He also revealed that they would have to read the actions taken to find out what was done for that grievance. During an interview on 08/01/2025 at 11:15 AM, the Administrator and RVP asked this surveyor what was flagged on the Payroll Based Journal (PBJ). The Administrator stated they were always above the required staffing numbers. The reports provided titled Monthly Reporting Average Direct Care hours, showed the report was from a third-party service and was tallied on an average of staffing for the month not daily or per shift. He mentioned that they had different office personnel that were CNAs that would work the floor instead of in their office when they were short staffed. He stated when they worked the floor and not in their office, they would sign in on the daily staffing log for that shift, with the hours worked. A review of a facility policy titled, Facility Assessment, dated 05/26/2025, indicated they had an average daily census of 105-110. Common diagnoses of the facility's residents included psychiatric/mood Disorders, heart and circulatory system disorders, intellectual disabilities, neurological system disorders, vision and hearing disabilities, musculoskeletal system disorders, cancers, respiratory disorders, metabolic disorders, genitourinary disorders, blood diseases, digestive system disorders, skin conditions and infectious diseases.

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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. Based on observation, interview, and facility policy review, the facility failed to ensure that the dish washing machine vent hood was free of rust; the pest trap was free of rust and dirt; two of three ice machines were maintained in a clean and sanitary condition in one of two kitchens; expired food item was promptly removed / discarded on or before the expiration or use by date, and dietary staff washed their hands before handling clean equipment or food items for two of two meals observed.Based on observation, interview, and facility policy review, the facility failed to ensure a pest trap was free of rust and dirt and kept away from meal preparation areas; two of three ice machines were maintained in a clean and sanitary condition in one of two kitchens; expired food items were promptly removed and discarded on or before the expiration or use by date, and dietary staff washed their hands before handling clean equipment or food items for two of the two meals observed. The findings include: During an observation and concurrent interview on 07/28/25 at 10:10 AM, one box on a shelf under the food preparation counter contained 10 bags of 12 hot dog buns. Another box contained two bags of 12 hot dog buns with a received date of 07/09/2025. All hot dog buns showed a sage discoloration on them. The Dietary Manager (DM) stated there was mold on the hot dog buns. The manufacturer's specification on the box indicated for the hamburger buns and hot dog buns to be kept frozen at 0 degrees Fahrenheit or below. The DM stated the hot dog buns had been out of the freezer since they were received. The facility Dietician verified that the buns were supposed to be kept frozen. Once removed from the freezer, they should be used within seven to 10 days. During an observation and concurrent interview on 07/28/25 at 10:30AM, Dietary Aide (DA) #1 lifted the trash can lid and threw away a tissue. Without washing her hands, she picked up cups by the rim and placed them on the trays to be used in serving beverages to the residents for the supper meal. DA #1 stated she should have washed her hands after touching the trash can. During an observation and interview on 07/28/25 at 11:21 AM, the metal covering of the pest trap on the wall above the food preparation counter was rust colored and loose. The cord attached to the pest trap had a greasy, dusty substance stuck to it. The pest trap cord was hanging down toward a basket containing napkins with utensils meant for the residents to use during their meals. The DM stated that it should not have been there. During an observation and concurrent interview on 07/28/25 at 11:27 PM, Dietary [NAME] (DC) #2 turned on the sink faucet to wash the blender bowl, blade, and lid. After sanitizing the equipment, DC #2 turned off the faucet with her bare hand. Without washing her hands, she then picked up a clean blade and attached it to the blender to puree food items to be served to the residents. DC #2 stated she should have washed her hands after touching dirty objects and before handling clean equipment. During an observation on 07/28/25 at 12:19 PM, the following observations were made in the freezer in the treatment room on 400 hall. a. A box of crackers on top of the freezer had an expiration date of 05/08/25. b. A box of honey buns on top of the freezer had an expiration date of 07/15/25. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and concurrent interview on 07/28/25 at 12:28 PM, the ice machine located by the kitchen door, and the ice machine in the kitchen both had an accumulation of wet black residue at the corners of the panel inside the ice machine and on the area where ice traveled down to the ice collector. There was a wet accumulation of black residue on the inside body of the ice machine that was loose and could have fallen onto the ice. The DM stated she cleaned the ice machine once a week. She also verified that the Certified Nursing Assistants used the ice for the water pitchers in the residents' rooms and the ice machine in the kitchen was used to fill beverages served to the residents at mealtimes. The DM confirmed both ice machines were dirty with black residue. During an observation and concurrent interview on 07/28/25 at 1:17 PM, an opened box of tea was on a rack. The box was not covered or sealed, which exposed it to air, heat and moisture. The DM stated air getting in the bag would cause it to lose freshness. During an observation and concurrent interview on 07/28/25 at 5:13 PM, DC #3 removed gloves from her pocket, pushed a cart towards the food preparation table, contaminating her hands in the process. Without washing her hands, she picked up a clean blade and attached it to the base of the blender to be used in pureeing food items. When DC #3 was ready to place corndogs into the blender to ground. This surveyor immediately stopped DC #3 before the blender could be used. DC #3 stated she should have washed her hands after touching dirty objects and before handling clean equipment. During an observation and concurrent interview on 07/29/25 at 8:10 AM, DC #4 turned on the three-compartment sink faucet and rinsed a spatula. After rinsing the spatula, DC #4 turned off the faucet with her bare hand. Without washing her hands, she then placed gloves on her hands. Then DC #4 removed slices of bread from the bread bag to be used in preparing French toast for breakfast. This surveyor immediately stopped DC #4, who stated she should have washed her hands after touching dirty objects and before handling food items. During an observation and concurrent interview on 07/29/25 at 8:25 AM, DC #5 turned on the two-compartment sink faucet and washed her hands. After washing her hands, she turned off the faucet with her bare hand. Without washing her hands, DC #5 picked up a bowl with her fingers inside the bowl and poured instant oatmeal into the bowl to be prepared and served the residents. DC #5 stated that she should have washed her hands after touching dirty objects and before handling clean equipment. A review of the facility policy titled, Hand washing and glove usage in food service, indicated hands should be washed before starting work, after leaving and returning to the kitchen preparation area and after touching anything else such as dirty equipment and work surfaces. A review of the facility policy titled, [Name brand and model] Ice Machine Technician's Handbook, Indicated under preventative maintenance cleaning that the cleaning procedure can be performed between the bi-annual cleaning and sanitizing cycles and does not require removing the ice from the ice bin.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on record review, interviews, and social media observations, the facility failed to ensure a resident's photograph was not posted on social media without permission and was not visible to the public or other residents, to maintain dignity and privacy for one (Resident #70) of one resident observed.The findings include:Record review of a document titled, Division of Aging and Adult Services, dated 03/06/2017, indicated that Adult Protective Services (APS) was Resident #70's custodian.Record review of a document titled, Physician Affidavit, dated 12/03/2018, indicated Resident #70 was mentally and physically impaired and the physician recommended that the resident remain in the protective custody of the Arkansas Department of Human ServicesReview of photos posted on social media under the facility's page revealed photos of Resident #70. Included were photos showing Resident #70 with food stains on the resident's shirt and the resident eating with food on their mouth. During an interview on 07/31/2025 at 9:47 AM, Human Resources indicated that the Activities Department was responsible for displaying any photographs of the residents on the facility's social media. She indicated that permission to display a resident's photograph should be obtained during the admission process.During an interview on 07/31/2025 at 10:10 AM, the Social Services Director (SSD) indicated that even if Resident #70 had given consent to have their photograph taken, if the resident did not look presentable in the photograph, she would expect that the photograph would be deleted. She also indicated if a facility posted a photograph of a resident on social media without consent of the resident that would be against their rights.During an interview on 07/31/2025 at 10:35 AM, the Activities Director (AD) indicated that during admission to the facility the SSD obtained permission from the resident or resident's representative to take and display photographs of the resident during activities. She indicated she could take photographs and display the photographs on the facility's social media page. She also indicated that the Administrator, the Assistant Administrator, and the Director of Nursing may also post photographs to the social media page. She added she was the main staff member to add photographs of residents to social media. She indicated if a photograph was appropriate, she could post it. She reported only family members could join the facility's social media account. She indicated that on 07/31/2025 there were 1,800 followers that would be able to view the photographs posted on the facility's social media page. She reported that even if Resident #70 had given permission for photographs to be taken and a photograph was taken where the resident was not presentable, she would expect that the photograph would be deleted and not displayed.During a telephone interview on 07/31/2025 at 2:48 PM, Resident #70's APS guardian stated the facility cannot have Resident #70's photo displayed. The APS Guardian reported she was not aware that the resident's photographs were on social media or any other public viewable forum. She also indicated that when a resident was under custody of APS, the resident's identifying photo may be taken and posted on the resident's admission record only. She reported that the facility does not have permission to post the resident's photo to any social media or any other public viewable forum. She indicated the facility should have admission paperwork filled out by APS that specifically states permission was not given to post the resident's photo. The APS guardian reported Resident #70 became custody of APS in September of 2016.During an interview on 07/31/2025 at 5:09 PM, the AD verified the photos from the facility's social media page were Resident #70 with food stains on their shirt and the resident eating with food on their mouth. The AD verified that the background in the photograph was the inside of the facility and that she had taken the photographs of Resident #70 and posted the photographs to the facility's social media. She indicated she would not want the facility represented by photos of residents with food on resident's mouths and clothes. AD stated I am pretty sure the resident was able to consent to having photographs taken and posted for public display.During a telephone interview on 08/01/2025 at 12:06 PM, Resident #70's APS guardian reported she had been unable to locate the resident's admission paperwork at the APS office. She reported that the facility should have the admission paperwork (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which was signed by APS when the resident was taken under custody of APS.During an interview on 08/01/2025 at 12:32 PM, the Administrator reported that the facility had multiple social media accounts. The Administrator stated the AD, assistant administrator, and the administrator all have permission to post photographs of residents on the facility's social media page. He indicated that he was responsible for the social media of the facility. He also indicated the AD posted most photos and the facility would need a photograph release form with permission from the residents, if they were their own responsible person. He verified that the facility social media account was publicly shared. The Administrator stated he did not realize the site had 1,800 followers who would be allowed to view the posted photographs of the residents. He reported he did not know if Resident #70 could provide consent for themselves. He stated APS was the guardian for Resident #70. The Administrator also indicated the facility did not have a policy for social media display and he was not aware of any rules of not posting the photograph of a resident in custody of APS. He described Resident #70 in the photograph that was posted on the facility's social media. He also described Resident #70 as having food on their face and on both sides of Resident #70's mouth. The Administrator indicated Resident #70's photographs should not be posted on social media without signed consent. Review of a facility policy titled, Resident Rights and Responsibilities, indicated every resident will be treated with consideration, respect and full recognition of dignity and individuality. It further indicated every resident has the right to know that photographs and interviews shall not be released without written consent of the resident or responsible party.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045147	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookridge Cove Rehabilitation and Care Center	1000 Brookridge Lane Morrilton, AR 72110

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, interviews, and facility policy review, it was determined the facility failed to ensure that staff performed proper hand hygiene when providing incontinent care for two (Resident #56 and Resident #92) of two residents observed and followed Enhanced Barrier Precautions (EBP) for one (Resident #92) of one resident observed for EBP. The findings include: Resident #56 On 07/30/2025 at 9:40 AM, during an observation of incontinent care for Resident #56 this surveyor observed that Certified Nursing Assistant (CNA) #8 and CNA #7 did not utilize hand sanitizer at any time while providing incontinent care for Resident #56. After removing dirty gloves, CNA #8 and CNA #7 did not sanitize their hands before putting on clean gloves. Both CNA #8 and CNA #7 removed the dirty gloves, placed them in the trash bag and then reached into their scrub top to obtain new gloves without hand sanitizer being utilized. CNA #8 and CNA #7 both participated in the dirty and clean tasks of incontinent care. CNA #8 tucked used wipes between the resident's legs. CNA #8 wiped the resident's skin more than once with the same wipe, multiple times. CNA #7's name tag, bare skin on arms and scrub top were against the resident and the resident's bed linen multiple times during incontinent care. CNA #8 and CNA #7 both obtained clean wipes with dirty gloves. CNA #8 and CNA #7 were putting a clean brief on the resident, and both verbally verified they were finished with peri care. CNA #8 then used clean wipes to show this surveyor that Resident #56 was properly cleaned. The clean wipes had return of stool on the wipe which indicated the stool remained on the resident. Numerous wipes were required to continue cleansing the resident of stool. CNA #7 used the same dirty gloves utilized for perineal care, to close the wipes container, and place that container back with the resident's belongings beside the bed. She then used the same dirty gloves to move the room-separation curtain back. CNA #8 used dirty gloves utilized for perineal care to touch the door and doorknob going outside of the resident's room. She came back into the room, removed the gloves, then washed her hands in the resident's bathroom. During an interview on 07/30/2025 at 10:05 AM, CNA #7 indicated it was important for a CNA to perform proper hand hygiene before, during and after providing incontinent care to protect the resident from cross contamination and infections. She reported hands should also be properly cleaned every time gloves are put on or taken off. She verified she did not perform proper hand hygiene at any time while providing incontinent care to Resident #56. She indicated each wipe should be used for one swipe to cleanse a resident to prevent cross contamination. She reported it was not acceptable to tuck used wipes between a resident's legs because the wipe could be lost or forgotten and cause skin breakdown. She indicated proper incontinent care was necessary to prevent skin breakdowns and infections. During an interview on 07/30/2025 at 2:25 PM, CNA #8 indicated it was important for a CNA to perform proper hand hygiene before and after providing peri care, before and after putting on gloves and each time gloves were changed. She verified she did not perform proper hand hygiene at any time while providing incontinent care to Resident #56. She reported it was important to remove used gloves and perform proper hand hygiene before touching the door, doorknob, or other objects in a resident's room to prevent infection. She indicated each wipe should be used for one swipe to cleanse a resident to prevent cross contamination. She reported dirty wipes should not be tucked between a resident's legs because the wipe could be lost or get stuck and might cause skin breakdown. She (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated proper incontinent care was necessary to prevent discomfort, rash or bed sores. Resident #92 On 07/30/2025 at 10:20 AM, during an observation of incontinent care for Resident #92, CNA #7 washed her hands and put on clean gloves. She did not don a gown. While providing incontinent care of bowel and bladder for Resident #92, CNA #7 reached into her scrub top pocket for clean gloves without using hand sanitizer. CNA #7's skin and clothing touched the resident's skin, clothing and bedding several times during incontinent care. She touched the clean bed linen and resident with dirty gloves, multiple times. CNA #8 donned gloves without hand sanitizer being utilized and did not don a gown. She assisted Resident #92 with removing clothing, then designated herself as the clean side of peri care. Her arms and scrub top touched the resident's skin, clothes, and bedding multiple times. Licensed Practical Nurse (LPN) #6 entered Resident #92's room during incontinent care to provide wound care to the resident's groin. LPN #6 performed proper hand hygiene and donned gloves but did not don a gown when providing wound care. LPN #6's clothing touched the resident's legs and bedding during the wound care. Review of Resident #92's order dated 07/24/2025, revealed that the Stage 3 pressure injury to the right gluteal fold should be cleansed with wound cleanser and patted dry. Collagen powder should then be added to barrier cream and applied to the wound bed. The wound would be left open to air. Review of Resident #92's order dated 07/11/2025 revealed enhanced barrier precautions (EBP), gown and gloves were to be worn during any prolonged contact during personal care, transfers, and wound care During an interview on 07/30/2025 at 1:59 PM, CNA #7 reported EBP was important for the resident, so they did not get an infection. She reported she had not realized the resident had EBP in place and verified she did not wear a gown while providing peri care for Resident #92. CNA #7 also verified there was an EBP sign on Resident #92's door and indicated she should have worn a gown and gloves while providing peri care. CNA #7 verified she had not performed proper hand hygiene before, during and after peri care, or before and after each glove change. During an interview on 07/30/2025 at 2:25 PM, CNA #8 indicated it was important for a CNA to perform proper hand hygiene before and after providing peri care, before and after putting on gloves and each time gloves were changed. She verified she did not perform proper hand hygiene each time she changed gloves while providing incontinent care to Resident #92. She indicated that a CNA should wear a gown and gloves when they provided incontinent care to a resident on EBP. She reported she knew Resident #92 was on EBP because there was a sign on the resident's door indicating EBP. During an interview on 07/30/2025 at 2:15 PM, LPN #6 indicated she had not realized Resident #92 was on EBP. She stated she should have worn a gown when applying topical medication to the resident's wound and verified that she did not. She reported it was important to wear a gown when a resident was on EBP to protect the resident and staff from infection. During an interview on 07/30/2025 at 2:49 PM, the Assistant Director of Nursing (ADON) indicated proper hand hygiene should be performed before gloves are put on and each time before and after gloves are changed. She reported wipes may be used one time while providing peri care and the wipes should be discarded after one swipe to avoid cross contamination. The ADON reported dirty wipes should not be tucked in between a resident's legs while providing incontinent care. She indicated skin (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breakdown; urinary tract infections and excoriation could result from improper incontinent care. The ADON indicated a CNA would know if a resident was on EBP because there would be a sign indicating that information on the resident's door. She reported CNAs and nurses should wear gowns and gloves when providing incontinent care to a resident on EBP. During an interview on 07/31/2025 at 1:02 PM, the Director of Nursing (DON) reported CNAs should sanitize their hands before starting incontinent care, each time gloves are removed, and at the completion of the care. She indicated that neither a resident's door nor doorknob should be touched with dirty gloves. The DON reported, during incontinent care each wipe should be used one time then thrown away. Dirty wipes should immediately be thrown in the trash and never tucked between a resident's legs. She indicated skin breakdown could be the result of improper incontinent care. The DON reported CNAs should wear gloves and gowns when providing incontinent care to a resident on EBP. She then added that a nurse should wear gloves and a gown when applying a topical medication to an open wound when a resident was on EBP. Review of a policy titled, Peri-care Procedure, indicated hands should be washed when entering a resident's room, before putting on gloves, after removing gloves, and before leaving the resident's room. It is stated be sure to wipe the crack until area is clean. It indicated one wipe for each swipe. Review of a facility policy titled, Handwashing, indicated hands should be washed when entering a resident's room. Review of a facility policy titled, Hand Hygiene, indicated hand hygiene will be performed, using proper technique consistent with accepted standards of practice. Review of a facility policy titled, Enhanced Barrier Precautions, indicated enhanced barrier precautions (EBP) refers to the use of gown and gloves during high-contact resident care activities. High-contact resident care activities included providing hygiene and changing briefs. The policy also indicated the initiation of enhanced barrier precautions will be obtained for residents with a wound and should be used for the duration of the resident's stay or until the wound heals.