STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056488	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Nursing Center	22617 S. Vermont Ave Torrance, CA 90502

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, facility failed to ensure a resident (Resident 5) who had impaired mobility, orders for physical therapy ([PT] a healthcare specialty that focusses on restoring, maintaining, and improving physical function and movement) and occupational therapy ([OT] a healthcare specialty that focusses and helps people of all ages participate in meaningful daily activities) evaluation and treatment were carried out for one of five sampled residents (Resident 5). This deficient practice resulted in a 30-day delay in treatment and services for Resident 5 and placed Resident 5 at risk for further decline. Findings: During a review of Resident 5 ' s admission Record (Face Sheet), the Face Sheet indicated Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including muscle wasting (weakening, shrinking, and loss of muscle), atrophy (the decrease in size and wasting of muscle tissue), and muscle weakness (a lack of muscle strength). During a review of Resident 5' s Minimum Data Set ([MDS] a resident assessment tool) dated 4/10/2025, the MDS indicated Resident 5 ' s cognition was intact. The MDS indicated Resident 5 required partial/moderate assistance (helper does more than half the effort) from staff for toileting hygiene, showering/bathing, lower body dressing, putting on/taking off footwear, sit to stand (ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed), and toilet transfer. The MDS further indicated Resident 5 used a manual wheelchair during the assessment period. During a review of Resident 5 ' s Order Summary Report (Physician ' s Orders), dated 5/6/2025, the Order Summary Report indicated Resident 5 had an order to receive PT and OT services, ordered on 5/6/2025. During a continued review of Resident 5 ' s Order Summary Report, dated 6/6/2025, the Order Summary Report indicated Resident 5 had an order to receive the following: 1. OT with self-care, neuromuscular (relating to nerves and muscles) re-education (NMRE), therapeutic exercises and therapeutic activities for treatment of muscle wasting and atrophy eight times in three weeks, ordered on 6/6/2025 (30 days after the order for OT was placed on 5/6/2025). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. PT for gait, NMRE, therapeutic exercises, wheelchair management, for treatment of unsteadiness on feet, eight times in three weeks, ordered on 6/6/2025 (30 days after the order for PT was placed on 5/6/2025). During a review of Resident 5 ' s Clinical Record (Care Plan section) revised 6/6/2025, the Care Plan indicated Resident 4 required PT and OT for impaired strength, impaired hygiene and grooming, impaired feeding, impaired upper and lower body bathing, impaired upper and lower body dressing, impaired toilet/tub/shower transfers, impaired static (means staying in one position without much movement for a prolonged period)/dynamic (is the ability to maintain your body's stability while moving or changing positions) balance in sitting/standing, impaired activity tolerance, impaired ambulation, impaired strength and impaired transfers. During a review of Resident 5 ' s Therapy Progress Note dated 6/6/2025, the Therapy Progress Note indicated Resident 5 received a PT and OT evaluation and was educated on the importance of getting out of bed and time using bedside commode (is a portable toilet) to prevent decline. During an interview on 6/6/2025 at 10:41 a.m., with the Director of Rehabilitation (DOR), the DOR stated she did not receive the order for Resident 5 ' s authorization for PT/OT until 6/6/2025. The DOR stated the physicians order for PT/OT was placed on 5/6/2025 and it was the responsibility of the rehabilitation department to follow up with the authorization. The DOR stated that she was responsible for following up with Resident 5 ' s PT/OT authorization and order. The DOR stated that Resident 5 ' s order for PT/OT was delayed 30 days due to an issue with Resident 5 ' s authorization but did not follow-up with the insurance company until 6/6/2025. During an interview on 6/6/2025 at 5:01 p.m., with the Clinical Chief Officer (CCO), the CCO stated the facility ' s process of when an order is received for PT/OT evaluation/treatment, the nurse carries out the order, inform the resident and their family, and notify the Interdisciplinary Team ([IDT] a group of medical professionals from different disciplines who work together to help a resident achieve their goals. The CCO stated if the order is for PT/OT, the order gets related to the rehabilitation department. The CCO stated that since this order was placed for PT/OT services, it was the responsibility for the rehabilitation department to follow up with the authorization and order should have been carried out on a timely manner. The CCO stated that this order should not have taken 30-days to get verified, authorized and carried out and on average this process should take no more than a week. During a review of the facility ' s Policy and Procedure (P&P) titled, Facility Director of Rehabilitation (DOR), dated 2/19/2021, the P&P indicated the DOR is responsible for tracking residents, including treatment minutes, and assessment dates. The DOR is responsible for tracking that clinical documentation by staff members of their respective facility(ies) are being completed accurately and in a timely manner. During a review of the facility ' s P&P titled Screening vs Evaluation, dated 2/19/2021, the P&P indicated the therapist will complete a skilled brief screening to gain an impression of resident functional status. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s P&P, titled, Supervising Occupational Therapist, dated 2/19/2021, the P&P indicated the duties and responsibilities are to receive and confirm OT evaluation and treatment orders. OT consults with resident ' s physician, develop and implement treatment plans for residents to restore and maintain their highest level of functioning, and reassess treatment results. The P&P indicated the Supervising OT will supervise and direct other personnel in giving treatment, closely following the physician ' s orders, regularly communicate with physicians, other therapy disciplines rehabilitation personnel and facility personnel to coordinate efforts toward optimal resident care. Based on interview, and record review, facility failed to ensure a resident (Resident 5) who had impaired mobility, orders for physical therapy ([PT] a healthcare specialty that focusses on restoring, maintaining, and improving physical function and movement) and occupational therapy ([OT] a healthcare specialty that focusses and helps people of all ages participate in meaningful daily activities) evaluation and treatment were carried out for one of five sampled residents (Resident 5). This deficient practice resulted in a 30-day delay in treatment and services for Resident 5 and placed Resident 5 at risk for further decline. Findings: During a review of Resident 5's admission Record (Face Sheet), the Face Sheet indicated Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including muscle wasting (weakening, shrinking, and loss of muscle), atrophy (the decrease in size and wasting of muscle tissue), and muscle weakness (a lack of muscle strength). During a review of Resident 5' s Minimum Data Set ([MDS] a resident assessment tool) dated 4/10/2025, the MDS indicated Resident 5's cognition was intact. The MDS indicated Resident 5 required partial/moderate assistance (helper does more than half the effort) from staff for toileting hygiene, showering/bathing, lower body dressing, putting on/taking off footwear, sit to stand (ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed), and toilet transfer. The MDS further indicated Resident 5 used a manual wheelchair during the assessment period. During a review of Resident 5's Order Summary Report (Physician's Orders), dated 5/6/2025, the Order Summary Report indicated Resident 5 had an order to receive PT and OT services, ordered on 5/6/2025. During a continued review of Resident 5's Order Summary Report, dated 6/6/2025, the Order Summary Report indicated Resident 5 had an order to receive the following: 1. OT with self-care, neuromuscular (relating to nerves and muscles) re-education (NMRE), therapeutic exercises and therapeutic activities for treatment of muscle wasting and atrophy eight times in three weeks, ordered on 6/6/2025 (30 days after the order for OT was placed on 5/6/2025). 2. PT for gait, NMRE, therapeutic exercises, wheelchair management, for treatment of unsteadiness on feet, eight times in three weeks, ordered on 6/6/2025 (30 days after the order for PT was placed on 5/6/2025). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 5's Clinical Record (Care Plan section) revised 6/6/2025, the Care Plan indicated Resident 4 required PT and OT for impaired strength, impaired hygiene and grooming, impaired feeding, impaired upper and lower body bathing, impaired upper and lower body dressing, impaired toilet/tub/shower transfers, impaired static (means staying in one position without much movement for a prolonged period)/dynamic (is the ability to maintain your body's stability while moving or changing positions) balance in sitting/standing, impaired activity tolerance, impaired ambulation, impaired strength and impaired transfers. During a review of Resident 5's Therapy Progress Note dated 6/6/2025, the Therapy Progress Note indicated Resident 5 received a PT and OT evaluation and was educated on the importance of getting out of bed and time using bedside commode (is a portable toilet) to prevent decline. During an interview on 6/6/2025 at 10:41 a.m., with the Director of Rehabilitation (DOR), the DOR stated she did not receive the order for Resident 5's authorization for PT/OT until 6/6/2025. The DOR stated the physicians order for PT/OT was placed on 5/6/2025 and it was the responsibility of the rehabilitation department to follow up with the authorization. The DOR stated that she was responsible for following up with Resident 5's PT/OT authorization and order. The DOR stated that Resident 5's order for PT/OT was delayed 30 days due to an issue with Resident 5's authorization but did not follow-up with the insurance company until 6/6/2025. During an interview on 6/6/2025 at 5:01 p.m., with the Clinical Chief Officer (CCO), the CCO stated the facility's process of when an order is received for PT/OT evaluation/treatment, the nurse carries out the order, inform the resident and their family, and notify the Interdisciplinary Team ([IDT] a group of medical professionals from different disciplines who work together to help a resident achieve their goals. The CCO stated if the order is for PT/OT, the order gets related to the rehabilitation department. The CCO stated that since this order was placed for PT/OT services, it was the responsibility for the rehabilitation department to follow up with the authorization and order should have been carried out on a timely manner. The CCO stated that this order should not have taken 30-days to get verified, authorized and carried out and on average this process should take no more than a week. During a review of the facility's Policy and Procedure (P&P) titled, Facility Director of Rehabilitation (DOR), dated 2/19/2021, the P&P indicated the DOR is responsible for tracking residents, including treatment minutes, and assessment dates. The DOR is responsible for tracking that clinical documentation by staff members of their respective facility(ies) are being completed accurately and in a timely manner. During a review of the facility's P&P titled Screening vs Evaluation, dated 2/19/2021, the P&P indicated the therapist will complete a skilled brief screening to gain an impression of resident functional status. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P, titled, Supervising Occupational Therapist, dated 2/19/2021, the P&P indicated the duties and responsibilities are to receive and confirm OT evaluation and treatment orders. OT consults with resident's physician, develop and implement treatment plans for residents to restore and maintain their highest level of functioning, and reassess treatment results. The P&P indicated the Supervising OT will supervise and direct other personnel in giving treatment, closely following the physician's orders, regularly communicate with physicians, other therapy disciplines rehabilitation personnel and facility personnel to coordinate efforts toward optimal resident care.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Restorative Nurse Assistant 1 ([RNA 1] assists patient in maintaining and improving their physical and cognitive function, primarily focusing on maximizing their independence with activities of daily [ADLs] activities such as bathing, dressing and toileting a person performs daily) doffed (carefully removing personal protective equipment [PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments] to reduce the risk of contamination to self, other, or the surrounding environment) upon exiting a resident ' s room (Resident 4), who was on Enhanced Barrier Precautions ([EBP] involve gown and glove use during high contact resident care activities for residents at risk for Multidrug-Resistant Organisms ([MDRO] bacteria that have become resistant to certain antibiotics) for one of five sampled resident ' s (Resident 4). This failure had the potential to result in the transmission and cross-contamination of infectious microorganisms (germs) to all residents, staff, and/or visitors in the facility. Findings: During a review of Resident 4 ' s admission Record (Face Sheet), the Face Sheet indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including end-stage renal disease ([ESRD] irreversible kidney failure), dependence on renal (kidney) dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), type 2 diabetes ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing), and pressure ulcers (bed sores) areas of skin and tissue damage caused by prolonged pressure). During a review of Resident 4 ' s History and Physical (H&P), dated 6/5/2025, the H&P indicated Resident 1 had limited decision-making capacity. During a review of Resident 4 ' s Orders Summary Report (Physician ' s Orders) dated 6/4/2025, the orders indicated Resident 4 was on EBP due to Resident 4 having dialysis access (a medical device [port] which is surgically created that provides a way to connect a patient ' s bloodstream to a dialysis machine). During an observation on 6/5/2025 at 10:40 a.m., on the wall outside of Resident 4 ' s room, an EBP precautions sign was observed posted outside Resident 4 ' s room and on a storage bin where PPE was stored. The EBP sign indicated staff must clean hands upon entering and exiting the room, wear gloves and a gown during high-contact resident care activities (ADLs which include toileting, changing incontinence briefs, caring for devices, giving medical treatments, wound care, mobility assistance and preparing to leave the room, and cleaning the environment). During a continued observation on 6/5/2025 at 10:42 a.m., outside of Resident 4 ' s room, RNA 1 was observed exiting Resident 4 ' s room, walk in the facility hallway, grabbed an oxygen tank, then took the tank back into Resident 4 ' s room. RNA 1 did not doff gloves, gown, nor perform hand hygiene prior to exiting Resident 4 ' s room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/2025 at 10:58 a.m., with Registered Nurse Supervisor (RNS 1), RNS 1 stated Resident 4 was on EBP precautions because she (Resident 4) was on dialysis and had a dialysis port. RNS 1 stated Resident 4 was also on EBP precautions because she (Resident 4) recently underwent a right lower extremity (limbs, specifically hands and feet) amputation (is the surgical removal of all or part of a limb or other body part, often due to serious injury, infection, or disease). RNS 1 stated that when providing direct patient care to residents on EBP precautions, staff must perform hand hygiene, wear a mask, gloves and gown, which must be removed prior to exiting the residents ' room. RNS 1 stated RNA 1 should have removed gloves, gown and perform hand hygiene prior to exiting the room. RNS 1 stated removing PPE and performing hand hygiene prior to exiting the Residents room is implemented to prevent the spread of infection and to prevent cross contamination. During an interview on 6/5/2025 at 12:48 p.m., with RNA 1, RNA 1 stated the purpose of residents being on EPB precautions is to protect them from infections and to prevent the spread of infections to other residents. RNA 1 stated she was transferring Resident 4 to the shower gurney when she realized she had forgotten Resident 4 ' s oxygen tank and walked out of Resident 4 ' s room to get one without realizing she should have taken off her PPE. RNA 1 admitted to not taking off her PPE prior to exiting Resident 4 ' s room. RNA 1 stated what she should have done was to take off her PPE and performed hand hygiene prior to exiting Resident 4 ' s room or could have asked for help form another staff member. During an interview on 6/6/2025 at 2:34 p.m., with the Director of Quality Assurance (DQA) currently covering for the Infection Prevention Nurse (a nurse who specializes in preventing and controlling the spread of infections in a healthcare setting). The DQA stated the facility ' s practice is to perform hand hygiene and don PPE before entering a resident ' s room, then doff PPE inside the room, and perform hand hygiene upon exit. The DQA stated RNA 1 should not have been wearing PPE when she exited Resident 4 ' s room and should had taken off her PPE and performed hand hygiene prior to exiting the room. The DQA stated the purpose of wearing PPE is to prevent the spread of infection to all residents, staff, and visitors. During an interview on 6/6/2025 at 5:01 p.m., with the Chief Clinical Officer (CCO), the CCO stated when staff are providing direct care to a resident on EBP, they must perform hand hygiene, don PPE which included mask, gloves and gown, prior to entering the resident ' s room. The CCO stated staff should doff their PPE inside the resident ' s room, perform hand hygiene, prior to exiting the resident ' s room. The CCO stated the purpose of wearing PPE for Resident on EBP precautions is to prevent and or decrease the spread of MDROs. The CCO stated that RNA 1 should have removed her PPE and performed hand hygiene prior to exiting Resident 4 ' s room. The CCO stated RNA 1 should have acknowledged the EBP signs posted on the outside of the Resident 4 ' s room and proper infection control guidelines should have been followed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled, Standard Precautions, revised 2/2025, the P&P indicated the policy of the facility to implement standard precautions in accordance with the most current infection control guidelines to prevent the spread of infectious agents. The purpose of standard precautions is to prevent the transmission of infectious agents and reduce the risk of infection for both healthcare personnel and residents. These precautions are designed to be applied universally in the care of all residents. EBP refers to an infection control intervention designed to reduce transmission of MDRO that employ targeted gown and glove use during high contact resident care activities. EBP is used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO to staff hands and clothing. PPE whenever there is an expectation of possible exposure to and infectious material. Prevent contamination of clothing and skin during the process of removing PPE. Before leaving the Resident ' s room or cubicle, remove and discard PPE and perform hand hygiene before leaving the resident environments. Based on observation, interview and record review, the facility failed to ensure Restorative Nurse Assistant 1 ([RNA 1] assists patient in maintaining and improving their physical and cognitive function, primarily focusing on maximizing their independence with activities of daily [ADLs] activities such as bathing, dressing and toileting a person performs daily) doffed (carefully removing personal protective equipment [PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments] to reduce the risk of contamination to self, other, or the surrounding environment) upon exiting a resident's room (Resident 4), who was on Enhanced Barrier Precautions ([EBP] involve gown and glove use during high contact resident care activities for residents at risk for Multidrug-Resistant Organisms ([MDRO] bacteria that have become resistant to certain antibiotics) for one of five sampled resident's (Resident 4). This failure had the potential to result in the transmission and cross-contamination of infectious microorganisms (germs) to all residents, staff, and/or visitors in the facility. Findings: During a review of Resident 4's admission Record (Face Sheet), the Face Sheet indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including end-stage renal disease ([ESRD] irreversible kidney failure), dependence on renal (kidney) dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), type 2 diabetes ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing), and pressure ulcers (bed sores) areas of skin and tissue damage caused by prolonged pressure). During a review of Resident 4's History and Physical (H&P), dated 6/5/2025, the H&P indicated Resident 1 had limited decision-making capacity. During a review of Resident 4's Orders Summary Report (Physician's Orders) dated 6/4/2025, the orders indicated Resident 4 was on EBP due to Resident 4 having dialysis access (a medical device [port] which is surgically created that provides a way to connect a patient's bloodstream to a dialysis machine). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/5/2025 at 10:40 a.m., on the wall outside of Resident 4's room, an EBP precautions sign was observed posted outside Resident 4's room and on a storage bin where PPE was stored. The EBP sign indicated staff must clean hands upon entering and exiting the room, wear gloves and a gown during high-contact resident care activities (ADLs which include toileting, changing incontinence briefs, caring for devices, giving medical treatments, wound care, mobility assistance and preparing to leave the room, and cleaning the environment). During a continued observation on 6/5/2025 at 10:42 a.m., outside of Resident 4's room, RNA 1 was observed exiting Resident 4's room, walk in the facility hallway, grabbed an oxygen tank, then took the tank back into Resident 4's room. RNA 1 did not doff gloves, gown, nor perform hand hygiene prior to exiting Resident 4's room. During an interview on 6/5/2025 at 10:58 a.m., with Registered Nurse Supervisor (RNS 1), RNS 1 stated Resident 4 was on EBP precautions because she (Resident 4) was on dialysis and had a dialysis port. RNS 1 stated Resident 4 was also on EBP precautions because she (Resident 4) recently underwent a right lower extremity (limbs, specifically hands and feet) amputation (is the surgical removal of all or part of a limb or other body part, often due to serious injury, infection, or disease). RNS 1 stated that when providing direct patient care to residents on EBP precautions, staff must perform hand hygiene, wear a mask, gloves and gown, which must be removed prior to exiting the residents' room. RNS 1 stated RNA 1 should have removed gloves, gown and perform hand hygiene prior to exiting the room. RNS 1 stated removing PPE and performing hand hygiene prior to exiting the Residents room is implemented to prevent the spread of infection and to prevent cross contamination. During an interview on 6/5/2025 at 12:48 p.m., with RNA 1, RNA 1 stated the purpose of residents being on EPB precautions is to protect them from infections and to prevent the spread of infections to other residents. RNA 1 stated she was transferring Resident 4 to the shower gurney when she realized she had forgotten Resident 4's oxygen tank and walked out of Resident 4's room to get one without realizing she should have taken off her PPE. RNA 1 admitted to not taking off her PPE prior to exiting Resident 4's room. RNA 1 stated what she should have done was to take off her PPE and performed hand hygiene prior to exiting Resident 4's room or could have asked for help form another staff member. During an interview on 6/6/2025 at 2:34 p.m., with the Director of Quality Assurance (DQA) currently covering for the Infection Prevention Nurse (a nurse who specializes in preventing and controlling the spread of infections in a healthcare setting). The DQA stated the facility's practice is to perform hand hygiene and don PPE before entering a resident's room, then doff PPE inside the room, and perform hand hygiene upon exit. The DQA stated RNA 1 should not have been wearing PPE when she exited Resident 4's room and should had taken off her PPE and performed hand hygiene prior to exiting the room. The DQA stated the purpose of wearing PPE is to prevent the spread of infection to all residents, staff, and visitors. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/6/2025 at 5:01 p.m., with the Chief Clinical Officer (CCO), the CCO stated when staff are providing direct care to a resident on EBP, they must perform hand hygiene, don PPE which included mask, gloves and gown, prior to entering the resident's room. The CCO stated staff should doff their PPE inside the resident's room, perform hand hygiene, prior to exiting the resident's room. The CCO stated the purpose of wearing PPE for Resident on EBP precautions is to prevent and or decrease the spread of MDROs. The CCO stated that RNA 1 should have removed her PPE and performed hand hygiene prior to exiting Resident 4's room. The CCO stated RNA 1 should have acknowledged the EBP signs posted on the outside of the Resident 4's room and proper infection control guidelines should have been followed. During a review of the facility's Policy and Procedure (P&P) titled, Standard Precautions, revised 2/2025, the P&P indicated the policy of the facility to implement standard precautions in accordance with the most current infection control guidelines to prevent the spread of infectious agents. The purpose of standard precautions is to prevent the transmission of infectious agents and reduce the risk of infection for both healthcare personnel and residents. These precautions are designed to be applied universally in the care of all residents. EBP refers to an infection control intervention designed to reduce transmission of MDRO that employ targeted gown and glove use during high contact resident care activities. EBP is used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO to staff hands and clothing. PPE whenever there is an expectation of possible exposure to and infectious material. Prevent contamination of clothing and skin during the process of removing PPE. Before leaving the Resident's room or cubicle, remove and discard PPE and perform hand hygiene before leaving the resident environments.