

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106083	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Freedom Pointe Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1460 El Camino Real Drive The Villages, FL 32159	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review the facility failed to ensure wound care and treatment was provided according to professional standards for 3 of 6 residents, Residents #4, #15, and #40, reviewed for skin conditions. Findings include: 1) During an observation on 1/26/2026 at 9:45 AM Resident #15 had a wound gauze dressing wrapped to the left upper arm that was not dated. During an interview on 1/26/2026 at 9:45 AM Resident #15 stated, The wound vac [vacuum, used to treat wounds] is not connected because when they were going to change it, they realized they did not have supplies for the suction. Review of Resident #15's physician order dated 1/9/2026 read, Cleanse: NPWT [Negative Pressure Wound Therapy] to Left Axilla @ 125 mmHg [at 125 millimeters of mercury] pressure. Remove dressing, cleanse wound with Dakins, apply skin prep to peri-wound area, apply drape to peri-wound area. Fill wound space with black foam, cover with drape. Do not apply foam directly to skin without drape barrier. Change dressing 3x [times] weekly, every day shift every Mon [Monday], Wed [Wednesday], Fri [Friday] and as needed for compromised drg [dressing] seal. Monitor NPWT to left axilla and canister. Notify MD [Medical Doctor] for s/s [signs/symptoms] of bleeding. If dressing is unable to maintain pressure, check for leakage and reinforce. If problem persists, remove and change entire dressing. When machine malfunctions and unable to fix it: remove granufoam, pack wound loosely with moist gauze, secure with secondary dressing and notify wound team every shift. Do not leave granufoam longer than 2 hours without a well functioning wound vac machine. Review of Resident #15's Treatment Administration Record for the month of January 2026 read, Cleanse NPWT to left Axilla. Documented on 1/23/2026 the order was coded with a 9 [other/see nurse notes]. Review of Resident #15's progress noted dated 1/23/2026 read, Awaiting Supplies. During an interview on 1/27/2026 at 3:45 PM Staff A, Licensed Practical Nurse (LPN) stated, We had to change the dressing, and we needed the suction and there were no supplies for the wound vac. The wound nurse is responsible for ordering supplies for the vacuum. I went to look and the wound care nurse was on vacation, and I went to his office. I notified both Unit Managers that we did not have the supplies to change her [Resident #15] dressing. My Unit Manager told me not to remove the dressing and wait for the supplies. The dressing was intact, that is why we did not remove it and the vacuum was working properly. We left the vacuum connected with the suction. [Staff B Registered Nurse's name] is the Unit Manager. The resident agreed to leave the dressing as is because if I remove it, we would not be able to put the vacuum back on and it would be a regular dressing. I don't know if she [Staff B] notified the provider. During an interview on 1/27/2026 at 4:00 PM the Director of Nursing (DON) stated, I was not aware of that [wound vac dressing was not changed due to not having supplies]. The wound care nurse is on vacation. It is not likely they did not have supplies, not normal here. Typically, the staff would have let me know. I need to look into what happened. During an interview on 1/28/2026 at 7:48 AM the DON stated, Supplies were here in the overflow storage, and the nurse was not sure where the supplies were located. I would expect them to notify the provider. During an interview on 1/29/2026 at 9:50 AM Staff B, RN (Registered Nurse) Unit Manager, stated, We were going to change [Resident #15's name] wound vac dressing and we did not have supplies to do the dressing change. We went to the supply room and were unable to locate the supplies. I did not call the provider, the 3-11 supervisor was aware, and we (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	spoke to the resident, and she was okay with leaving the dressing how it was. It was functioning correctly at that time. The supervisor was going to follow up after that. During an interview on 1/29/2026 at 10:07 AM Medical Doctor #1 stated, I did not know what was going on with the wound vac. If they did not have supplies, they would need to keep it closed until they have supplies again. I was not aware of it. During an interview on 1/29/2026 at 10:17 AM the Advance Practice Registered Nurse (APRN #1) stated, The staff called me and I gave instructions to change the dressing that Friday evening [01/23/2026] to a wet to dry dressing. During an interview on 1/29/2026 at 12:14 PM the DON stated, The staff did not change the dressing on Friday [1/23/2026]. The dressing was changed on Saturday [1/24/2026] because the suctioning was malfunctioning and the staff changed the dressing to moist dressing. They should have called me and double checked for the supplies. The supplies were available but in the overflow storage. If the staff were unable to change the dressing they should have contacted the provider. The night shift nurse did not contact the provider on Friday [1/23/2026]. The dressing should also have been dated when it was changed on 1/24/2026. Review of the facility policy and procedure titled Negative Pressure Wound Therapy with a last review date of 9/23/2025 read, Purpose: The purpose of this procedure is to provide guidelines for establishing and maintain negative pressure wound therapy (NPWT). General Guidelines: 3. Change dressings per physician orders and manufacturer guidelines. 2) During an observation on 1/26/2026 at 11:00 AM Resident #4 had a wound dressing to the left forearm. The wound dressing was not dated. [Photographic evidence obtained] During an interview on 1/26/2026 at 11:00 AM Resident #4 stated, This happened [dressing on left forearm] while I was in the exercise room and it [the wound dressing] has not been changed in about a week. Review of Resident #4's physician orders did not document a wound care order for the resident's left forearm. Review of Resident #4's medical record, the record did not contain documentation of the resident having suffered an injury resulting in a wound to the left forearm. During an observation on 1/27/2026 at 3:55 PM Staff C, RN of Resident #4, the resident was lying in bed and to his left arm there was a dressing dated 1/26/2026. Staff C peeled off the left corner of the dressing and there was a skin tear. Staff C placed the dressing back on Resident #4's arm. During an interview on 1/27/2026 at 4:00 PM Staff C, RN stated, I do not see any wound care orders for [Resident #4's name] left arm. During an interview on 1/29/2026 at 12:52 PM Medical Doctor #2 stated, No one had brought to my attention [Resident #4's name] had a skin tear in his left forearm. 3) During an observation on 1/26/2026 at 10:24 AM Resident #40 had a wound dressing to the left forearm dated 1/25/2026 with staff Initials. During an observation on 1/27/2026 at 10:40 AM Resident #40 had a wound dressing dated 1/25/2026 to the left arm. [Photographic evidence obtained] Review of Resident #40's physician orders did not contain an order for wound care for the resident's left arm. During an interview on 1/27/2026 at 3:50 PM Staff D, LPN (Licensed Practical Nurse) stated, I did not pay attention to the date on the dressing. I did see that the dressing looked old. I checked; there are no dressing change orders. During an interview on 1/27/2026 at 4:00 PM the Director of Nursing stated, Typically, we complete a risk and incident report. The nurse would do a skin assessment, let the wound care nurse know and put in orders in the system; making sure the wound care nurse sees it to make sure that no other treatment is required. The dressings should be dated. The incident report has a check list and notifying the doctor is part of it and depending on the circumstances family is also notified. During an interview on 1/29/2026 at 12:15 PM Medical Doctor #3 stated, I have not been informed of a skin tear to the left arm of [Resident #40's name]. There should be orders for wound care and treatment provided. The nurse should write a progress note documenting the notification. Review of the facility policy and procedure titled Care of Skin Tears-Abrasion and Minor Breaks with a last review date of 9/23/2025 read, Purpose: The purpose of this procedure is to guide the prevention and treatment of abrasions, skin tears, and minor breaks in the skin. Preparation. 1. Obtain a physician's order as needed. Document physician notification in medical record. Steps in the Procedure: 18. Apply the ordered dressing and secure with tape or border dressing per order. (Note: Use non-allergenic tape as indicated.) Label with date and initials to top of dressing.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview and record review the facility failed to ensure antibiotic medications were administered based on culture and sensitivity results for 1 of 6 residents, Resident #61, reviewed for medication management. Findings include: Review of Resident #61's physician order dated 1/21/2026 read, Cipro Oral Tablet 500 MG [milligram] (Ciprofloxacin HCl [Hydrochloride]) give 1 tablet by mouth two times a day for E. Coli UTI [Escherichia coli urinary tract infection] for 7 Days. Review of Resident #61's Medication Administration Record (MAR) for the month of January 2026 documented Cipro 500 mg was administered from 1/21/2026 to 1/27/2026. Review of Resident #61's Urine Culture [a lab test that will identify the bacteria causing the infection] with a reported date of 1/21/2026 read, Results: Escherichia coli (Isolate 1). Sensitivity Analysis. Ciprofloxacin R [Resistant/ineffective]. Review of Resident #61's physician follow up note dated 1/21/2026 read, Patient observed ambulating with physical therapy and doing well. Reviewed urine culture and sensitivity. Will have to discontinue Bactrim and change patient to cipro per sensitivity report. Patient otherwise doing well. During an interview on 1/28/2026 at 7:56 PM the Director of Nursing stated, I reviewed the culture and sensitivity and Cipro was resistant. There was a note in the system that stated the antibiotic was changed to cipro due to the sensitivity. Normally the results will come in and the Infection Preventionist will review the antibiotic and the sensitivity. The expectation and normal process is to make sure that the antibiotics prescribed are correct. During an interview on 1/28/2026 at 3:54 PM the Infection Preventionist stated, I don't remember that one [Resident #61's culture and sensitivity]. When I looked in the antibiotic time out it was the same day that the provider had changed it [the antibiotic] to cipro and I thought she had looked at it [the culture and sensitivity]. I understand now that I am to look at the culture to see if the antibiotic the provider changes it to is susceptible or not and notify the provider. During an interview on 1/29/2026 at 11:41 AM APRN #2 stated, The preliminary results showed E. Coli and I started her on Cipro. I have been notified that the antibiotic was resistive and had to be changed. Review of the facility policy and procedure titled Antibiotic Stewardship with a last review date of 9/23/2025 read, Policy Statement. Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. Policy Interpretation and Implementation: 11. When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 policy and procedure review the facility failed to ensure hot food items were maintained at the proper temperatures during meal service. Findings include:During an observation on 01/27/26 at 7:32 AM of the breakfast service on the [NAME] Wing, the Assistant Dietary Director was beginning to serve the breakfast meal. A review of the temperatures for the bacon, sausage patties, and hashbrowns the temperatures were 117 to 118 degrees Fahrenheit (F) on the steam table. During an interview on 01/27/26 at approximately 7:33 AM the Assistant Dietary Director verified the temperatures of the bacon, sausage patties, and hashbrowns.During an interview on 1/27/26 at approximately 8:00 AM the Dietary Director stated, The temperatures of 117 and 118 for hot food items are within the danger zone area.Review of the policy and procedure titled, Temperatures and Safe Food Handling last reviewed on 09/23/26 read, Objective: Participants will be able to understand the importance of proper temperatures and food handling procedures when handling food for residents. 2. e. Failure to reheat to 165 F or hold food at appropriate temperatures-cold food less than or equal to 41 F and hot foods more than or equal to 140 F.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review the facility failed to ensure residents' records were complete and accurate for documentation of provider notification when physician orders are not followed as prescribed for 2 of 6 residents, Residents #5 and #15, reviewed for medication management. Findings include: 1) Review of Resident #5's physician order dated 12/15/2025 read, Carvedilol Oral Tablet 12.5 MG [Milligram] (Carvedilol) Give 1 tablet by mouth two times a day for HTN [Hypertension].Review of Resident #5's Medication Administrator Record (MAR) for the month of January 2026 for Carvedilol 12.5 MG documented on 1/10/2026 at 1700 [5:00PM] blood pressure 119/58, Pulse 84, coded 4 (vital signs outside of parameters), dated 1/17/2026 at 1700 no blood pressure or pulse was documented, coded 5 (Hold/See Nurse Note), dated 1/18/2026 at 1700 blood pressure 109/52, pulse 84, coded 5, dated 1/22/2026 at 1700 blood pressure 100/73, Pulse 82, coded 4, dated 1/24/2026 at 0900 [9:00AM] no blood pressure or pulse documented, coded 4 and at 1700 blood pressure 104/57, pulse 82, coded 4, and dated 1/25/2026 at 0900 no blood pressure or pulse documented, coded 4.Review of Resident #5's progress note dated 1/17/2026 read, Held medication, BP [Blood Pressure] 108/50.Review of Resident #5's progress note dated 1/18/2026 did not contain documentation related to the resident's Carvedilol not being administered.Review of Resident #5's progress notes for the period of 01/10/2026 through 01/25/2026 did not contain documentation the physician was notified the resident's Carvedilol was not administered.During an interview on 1/28/2026 at 7:52 AM the Director of Nursing (DON) stated, I would expect nursing staff If they were going to hold a medication that does not have parameters and they have spoken to the provider they should document it in the record that they spoke to the provider.During an interview on 1/28/2026 at 1:59 PM Staff E Licensed Practical Nurse (LPN) stated, If the resident's blood pressure is low, I will hold the medication and notify the provider. I should have documented in the progress notes that I contacted the provider, but I do not think I did.During an interview on 1/28/2026 at 5:00PM with Staff F, LPN, stated, Sometimes [Resident #5's name] representative will not want the medication to be administer and if the blood pressure is to low, I will hold the medication. I will always contact her [Resident #5's] provider to let him know. I do not think I documented the notification in the system.During an interview on 1/29/2026 at 10:43 AM Medical Doctor #4 stated, The staff call me to notify when they are going to hold [Resident #5's name] medication. 2) Review of Resident #15's physician order dated 1/8/2026 read, Oxycodone HCl Oral Tablet 5 MG [Milligram] give 1 tablet by mouth every 8 hours as needed for Acute Pain (7-10).Review of Resident #15's MAR for the month of January 2026 documented Oxycodone 5 mg was administered on 1/6/2026 at 1248 [12:48 PM] pain level 6, dated 1/17/2026 at 1757 [5:57PM] pain level 6, dated 1/20/2026 at 2110 [9:10 PM] pain level 6, dated 1/21/2026 at 0652 [6:52 AM] pain level 5, dated 1/24/2026 at 1929 [7:29 PM] pain level 2, dated 1/25/2026 at 1236 [12:36 PM] pain level 4, and dated 2117 [9:17 PM] pain level 4.Review of Resident #15's progress notes did not contain documentation of provider notification regarding oxycodone being administered when the pain level was below the physician ordered parameters.During an interview on 1/27/2026 at 3:45 PM Staff A, LPN, stated, I was giving her oxycodone before her wound care changes. She [Resident #15] likes to take that medication to handle the pain. The doctor is aware that this is the resident's preference.During an interview on 1/28/2026 at 7:48AM the Director of Nursing stated, If the medication is outside parameters the staff need to speak to the provider and write a note and document they spoke to the provider.During an interview on 1/28/2026 at 1:159 PM Staff E, LPN, stated, I cannot recall , but I normally will not hold a medication that does not have parameters without contacting the provider.During an interview on 1/28/2026 at 5:00 PM Staff F, LPN, stated, I am new and still learning the system. I think I wrote the pain level wrong in that section.During an interview on 1/29/2026 at 10:17AM APRN # 1 stated, The staff call me about Resident #15's pain medication and request from the patient.Review of the facility (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy and procedure titled Administering Medications with a last review date of 9/23/2025 read, Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation. 4. Medication are administered in accordance with prescriber orders, including any required time frame. Review of the facility policy and procedure titled Charting and Documentation with a last review date of 9/23/2025 read, Policy Statement: All services provided to the resident, progress toward the care pan goals, or any changes in the resident's medical physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation. 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.		

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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 observation, interview, and record review the facility failed to prevent the possible spread of infection when not performing hand hygiene during wound care for 1 of 6 residents, Resident #15, reviewed for skin conditions. Findings include: Review of Resident #15's physician order dated 1/9/2026 read, Cleanse: NPWT [Negative Pressure Wound Therapy] to Left Axilla @ 125 mmhg [at 125 millimeters of mercury] pressure. Remove dressing, cleanse wound with Dakins, Apply skin prep to peri-wound area. Apply drape to peri-wound area. Fill wound space with black foam, Cover with drape. Do not apply foam directly to skin without drape barrier. Change dressing 3x [times] weekly. every day shift every Mon [Monday], Wed [Wednesday], Fri [Friday] AND as needed for compromised drg [dressing] seal. During an observation on 1/29/2026 at 11:45 AM the Wound Care Nurse performed hand hygiene, don a gown and two sets of gloves. The Wound Care Nurse entered Resident #15's room and placed the wound care supplies on top of Resident #15's cabinet without placing a barrier underneath. The Wound Care Nurse proceeded to clean Resident #15's bedside table, throwing away a water cup in the garbage, placing a newspaper on top of the resident's recliner, sanitized the bedside table, and placed the wound care supplies on the table. The Wound Care Nurse removed the top pair of gloves leaving the first original pair of gloves on, did not perform hand hygiene, put a new pair of gloves on, on top of the first original gloves. The Wound Care nurse removed the dressing from Resident #15's left arm, removed the top pair of gloves leaving the first original gloves on, did not perform hand hygiene, and put another pair of gloves on. The Wound Care Nurse cleansed the wound, pat dried the wound, removed the top pair gloves leaving the original pair of gloves on, did not perform hand hygiene, and put another pair of gloves on. The Wound Care Nurse applied a drape to the peri wound area, filled the wound with a black foam covering with a transparent drape, removed the top pair of gloves leaving the original pair on, did not perform hand hygiene, put a new set of gloves on, cut a hole in the barrier, and placed tubing with an adhesive pad over the wound. The wound care nurse proceeded to look for a new disposable canister for the wound vacuum system. One was not located in the resident's room. The Wound Care Nurse removed both sets of gloves, performed hand hygiene, and exited the room. The Wound Care Nurse returned to the room, performed hand hygiene, put two sets of gloves on, connected the canister tubing, and initiated the negative pressure on the pump for the wound vacuum as ordered. The wound care nurse dated the wound dressing, removed both sets of gloves, and performed hand hygiene. During an interview on 1/29/2026 at 12:15 PM the Wound Care Nurse stated, I should have performed hand hygiene when I took my gloves off. During an interview on 1/28/2026 at 1:00 PM the Director of Nursing stated, Staff should wash their hands in between each wound care step. The staff should take their gloves off and wash their hands and put a new pair of gloves on. During an interview on 1/28/2026 at 3:54 PM the Infection Preventionists stated, I would expect the staff to perform hand hygiene. I don't know why they are putting two sets of gloves on. They would need to remove both sets of gloves and put new gloves back on after washing their hands. Review of the facility policy and procedure titled Handwashing/Hand Hygiene with a last review date of 9/23/2025 read, 9. The use of gloves does not replace hand washing/hand hygiene. Review of the facility policy and procedure titled Negative Pressure Wound Therapy with a last review date of 9/23/2025 read, Steps in the procedure: 1. Identify and size the wound to be treated. 2. Wash hands and apply gloves. 3 Clean wound according to facility protocol, or as ordered. 4. Remove gloves. 5. Wash Hands and apply clean gloves. 6. Cut sponge dressing to size.		