STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155205	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greencroft Healthcare	1225 Greencroft Dr Goshen, IN 46527

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on observations, record review and interviews, the facility failed to ensure 1 of 3 residents reviewed for resident rights were informed of treatment and medication changes. (Resident 36) Finding includes: A record review For 36 was completed, on 5/21/2025. Diagnoses included, but were not limited to: anxiety disorder and major depressive disorder. A Significant Change Minimum Data Set (MDS) assessment, dated 4/22/2025, indicated Resident 36 had severe cognitive impairment and received anti-anxiety medication. A Physician's Order, dated 5/13/2025, indicated lorazepam 0.5 milligrams every four hours as needed. A Care Plan, dated 10/18/2024, indicated Resident 36 used anti-anxiety medication related to his diagnoses of anxiety. Interventions included, but were not limited to: assessing anxiety level and the need for anti-anxiety medication and administration of anti-anxiety medication per the physician order. During observations on 5/22/2025 at 9:22 A.M., 5/22/2025 at 1:48 P.M. and 5/23/2025 at 8:54 A.M., Resident 36 was observed lying in bed. During an interview, on 5/23/2025 at 9:06 A.M., QMA 2 indicated Resident 36 took lorazepam for restlessness. During an interview, on 5/23/2025 at 1:27 P.M., the Director of Nursing (DON) indicated a notification to Resident 36's representative of the risk of psychotropic medication use could not be found in the medical record. A policy was provided on, 5/23/2025 at 1:00 P.M., by the DON. The policy titled, Psychotropic Medication Policy, indicated, .Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication[s] .5. Residents and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-3(n)(2)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, record review and interview, the facility failed to provide a dignity bag to cover a urinary drainage bag for 1 of 2 residents reviewed for urinary catheters. (Resident 36) Finding includes: During an interview, on 5/19/2025 at 1:47 P.M., Resident 36's wife indicated Resident 36 had a suprapubic catheter and had had his urinary catheter for the past two and a half years. A record review for Resident 36 was completed on 5/21/2025. Diagnoses included, but were not limited to: retention of urine and pressure ulcer of sacral region. A Significant Change Minimum Data Set (MDS) assessment, dated 4/22/2025, indicted Resident 36 had severe cognitive impairment, had an indwelling urinary catheter, had an unstageable pressure ulcer and received hospice services. A Physician's Order, dated 5/18/2023, indicated catheter care- use a leg bag when out of bed and replace every shift with urinary drainage bag when in bed. A Care Plan, dated 5/31/2023, indicated Resident 36 had a suprapubic urinary catheter due to a history of urinary retention and a diagnosis of obstructive uropathy. Interventions included, but were not limited to: make sure the urinary catheter bag was emptied at the end of every shift and keep the closed urinary drainage system below the bladder. During an observation, on 5/22/2025 at 9:22 A.M., Resident 36 was observed lying in bed with the urinary drainage bag hooked to the bed frame. Yellow liquid was observed in the urinary drainage bag. A dignity cover was not over the urinary drainage bag and was visible to anyone entering the room. During an observation, on 5/22/2025 at 1:48 P.M., Resident 36 was observed lying in bed with the urinary drainage bag hooked to the bed frame. A dignity cover was not over the urinary drainage bag and was visible to anyone entering the room. During an observation, on 5/23/2025 at 8:54 A.M., Resident 36 was lying in bed, and the urinary drainage bag was seen from the hallway hanging to the bed frame. During an interview, on 5/23/3035 at 8:55 A.M., CNA 6 indicated the urinary drainage bag should have had a dignity cover. A policy was provided on, 5/23/2025 at 1:00 P.M., by the DON. The policy titled, Indwelling Catheter Use and Removal Policy, indicated, .It is the policy of this campus to ensure that indwelling catheters that are inserted or remain in place are justified or removed according to regulations and current standards of practice The policy did not address the use of a dignity bag for resident comfort. 3.1-3(t)

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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 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. Based on interview, observation and record review, the facility failed to ensure residents were informed of where the Ombudsman and other state agencies phone numbers were located. This had the potential to affect 145 of 145 residents who resided in the facility. Findings include: During the resident/surveyor meeting, on 5/20/2025 at 10:45 A.M., 11 of 11 residents in attendance indicated they were unaware of where the Ombudsman's contact information or telephone number and where a copy of resident rights was posted. During a random observation, on 5/20/2025 at 11:48 A.M., a poster of the resident rights was hung on a wall in a lounge area past the receptionist desk. A small desk was attached to the wall beneath the Resident Rights poster, making it difficult for a resident using a wheelchair for mobility to be able to visulize the entire poster. In the same lounge area, on a shelf, there was printed paper in a plastic stand with the Ombudsman phone numbers, the State health department and other required agencies and their contact information. During an interview, on 5/20/2025 at 12:10 P.M., the Administrator indicated the Resident Rights and Ombudsman phone numbers were easily accessible to the family. He indicated the residents had been given a handbook with this information on admission. The Administrator indicated the information for the Ombudsman and the Resident Rights should probably be in each hall. On 5/23/2025 at 1:00 P.M., the Administrator provided the policy titled, Facility Required Postings, dated 8/1/2024, and indicated the policy was the one currently used by the facility. The policy indicated .The campus will post required postings in an area that is accessible to all team member(s) and residents 3.1-4(j)(3)

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to limit an as needed psychotropic medication to a 14-day duration without required documentation for continued use of the psychotropic med for 1 of 5 residents reviewed for unnecessary medications. (Resident 36) Finding includes: A record review For 36 was completed, on 5/21/2025. Diagnoses included, but were not limited to: anxiety disorder and major depressive disorder. A Significant Change Minimum Data Set (MDS) assessment, dated 4/22/2025, indicated Resident 36 had severe cognitive impairment and received antianxiety medication. A Physician's Order, initiated on 11/14/2024 and discontinued on 1/6/2025, indicated lorazepam 0.5 milligrams (an antianxiety medication) every four hours as needed. A Physician's initiated on 1/6/2025 and discontinued on 3/14/2025, indicated lorazepam 0.5 milligrams every four hours as needed. A Psychiatric Progress Note, dated 12/2/2024, had no documentation of the lorazepam use. A Psychiatric Progress Note, dated 12/30/2024 and 1/27/2025, indicated Resident 36 was co-managed with hospice services and his symptoms were currently managed with citalopram 30 milligrams. The note had no mention of the lorazepam use. Resident 36 received lorazepam, on 12/3/2024, 12/10/2024, 12/12/2024, 12/22/2024, 12/28/2024, 12/29/2024,1/22/2025, 1/28/2025, 1/29/2025, 1/30/2025, 2/4/2025 and 2/20/2025, beyond the 14-day as needed limit without documentation for continued use of the medication. A Care Plan, dated 10/18/2024, indicated Resident 36 used anti-anxiety medication related to his diagnoses of anxiety. Interventions included, but were not limited to: assessing anxiety level and the need for anti-anxiety medication and administration of anti-anxiety medication per the physician order. During an interview, on 5/23/2025 at 9:06 A.M., QMA 2 indicated Resident 36 took lorazepam for restlessness. During an interview, on 5/23/2025 at 9:17 A.M., LPN 3 indicated as needed psychotropic medications had a limit of 14 days for use. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy was provided on, 5/23/2025 at 1:00 P.M., by the DON. The policy titled, Psychotropic Medication Policy, indicated, .Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication[s] .10. PRN [as needed] orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration [i.e. 14 days] .a. If the attending physician or prescribing practitioner believes this it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document that rationale in the resident's medical record and indicate the duration for the PRN order 3.1-48(a)(2)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure required transfer and resident clinical information was completed for 2 of 4 residents reviewed for transfers. (Residents 140 &148) Findings include: 1. The record for Resident 148 was reviewed on 5/22/2025 at 11:51 A.M. Diagnoses included, but were not limited to heart failure, depression, arthritis, pain, diabetes, atrial-fibrillation and septicemia. Resident 148 was admitted on [DATE] and discharged on 5/10/2025. A Nurses Progress Note, dated 5/9/2025 at 2:38 P.M., indicated the resident had complaint of nausea that morning and had been given Zofran, (antiemetic to prevent nausea and vomiting). The resident had continued to refuse medications because they made her sick to her stomach. A Nurses Progress Note, dated 5/10/2025 at 10:54 P.M., indicated Resident 148 had been admitted to the hospital according to the ER nurse. A Nurses Progress Note, dated 5/12/2025, indicated the nurse had received a text from the resident's daughter. The daughter and the resident did not want to hold the resident's bed. They planned to return home with hospice services. A Copy of the Bed Hold form were mailed to Resident. On 5/23/2025 at 12:03 P.M., the Director of Nurses provided a copy of a Notice of Transfer or Discharge form, a progress note dated 5/12/2025 and 11 pages of Resident 148's orders. The record lacked copies of transfer documentation including: the bed hold, the resident's clinical status prior to the transfer, reason for the transfer and most recent diagnostic and lab tests. On 5/23/2025 at 3:10 P.M., the Director of Nursing indicated she could not provide any transfer document or a checklist of what was sent with the resident. She indicated the facility had sent a list of the residents' medications, the POA (power of attorney) information, and had called the hospital to give report. 2. The record for Resident 140 was reviewed on 5/22/2025 at 11:00 A.M. Diagnoses included, but were not limited to malnutrition, atrial valve disorder, cancer and heart failure. Resident 140 was admitted on [DATE] and discharged on 3/31/2025. A Nurses Progress Note, dated 3/31/2025 at 1:34 A.M., indicated the NP (Nurse Practitioner) had been called to notify her of the resident's elevated temperature and low blood pressure. The family had been notified of Resident 140's change of condition and requested the resident be sent out to the ER (emergency room). A Nurses Progress Note, dated 3/31/2025, indicated the EMT (emergency medical technicians) were there to transport the resident to the hospital. A report had been called to the hospital and all the paperwork needed had been provided. The resident's daughter was to meet the resident at the hospital. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/23/2025 at 12:04 P.M., the Director of Nurses provided a copy of a Do Not Resuscitate Declaration and Order, copies of medical and financial POA's (Power of Attorney), a progress note, dated 4/1/2025, indicating the facility was unable to reach the family to provide the bed hold informstion prior to the resident's passing/expiring in the hospital, and 11 pages of the Resident 148's orders. The record lacked copies of transfer documentation including: the bed hold form, the resident's clinical status prior to the transfer, the reason for the transfer and the most recent diagnostic and lab tests. On 5/23/2025 at 2:28 P.M., the Director of Nursing indicated she could not provide any sort of transfer document or even a check list for Resident 148. She indicated the facility had sent a list of the residents' medications, the POA (power of attorney) information, and had called the hospital to had give a veral report. On 5/23/2025 the facility policy was requested regarding Discharge/Transfers but one was not provided prior to the survey exit. 3.1-12(a)(6)(A)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to develop person centered care plans for a new pressure area and refusal to have facial hair removed for 2 of 31 residents whose care plans were reviewed. (Resident 94 and 33) Findings include: 1. During an interview, on 5/21/2025 at 9:19 A.M., CNA 18 indicated she thought Resident 94 had a very small area on his bottom last week. She indicated it's an independence thing with him. He always wants to stay in his wheelchair because he knows he can go whenever he wants to. She indicated therapy had been working with the resident on self-transfers in and out of bed. During an observation, on 5/21/2025 at 9:26 A.M., Resident 94 was assisted to the bathroom where he was able to stand upright while holding onto the toilet seat riser bars. The aide pulled his pants down and Resident 94 had an open area to the left inner buttock cheek. No dressing was observed covering the area. The record for Resident 94 was completed on 5/21/2025 at 9:37 A.M. Diagnoses included, but were not limited to chronic kidney disease, hemiplegia, insomnia, low back pain, restless leg syndrome and venous insufficiency. A current Care Plan, dated 2/16/2024, indicated the resident had the potential for or actual skin impairment related to venous insufficiency, end stage chronic kidney disease, right hemiplegia and frail skin that tears easily. Interventions included but were not limited to: Observe resident's skin daily with care. Report any changes in skin integrity to nurse. Encourage/assist with frequent position changes if a resident is sitting or lying in the same position for extended periods of time. A current Care Plan, dated 2/16/2024, indicated the resident had impaired physical mobility related to end stage renal failure, bursitis, cellulitis, neck pain, low back pain, right side hemiplegia, venous insufficiency. Interventions included but were not limited to assisting with ADL's (activities of daily living) as directed. He required staff to assist as needed with bed mobility, transfers and toileting and assist/encourage resident to participate with ADL tasks. A current Care Plan, dated 2/16/2024, indicated the resident's skin would remain clean, dry and free of breakdown related to incontinence. Interventions included but were not limited to: Perineal cleansing and apply protective skin barrier after each incontinent episode. Assess and report signs of impaired skin integrity or breakdown. A current Care Plan, dated 5/21/2024, indicated Resident 94 was at risk for further impaired skin integrity related to impaired mobility, moisture, history of pressure ulcers and cellulitis. Interventions included but were not limited to alternating air loss mattress, pressure reducing cushion for wheelchair, treatments as ordered and offer peri care after incontinent episodes and every shift. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 5/21/2025 at 10:33 A.M., RN 19 indicated she thought she was notified of the open area on Resident's 94 left buttock cheek. RN 19 was questioned about the procedure when a new skin issue was observed to a resident. RN 19 indicated the area was to be measured, a skin incident was to be completed and entered into the computer, and the physician, family and management were to be notified. RN 19 indicated there was no Skin Incident and no current treatment order for Resident 94's open area. She indicated there should have been a Skin Incident, a treatment order in place and a care plan initiated for the open area. 2. During an observation, on 5/19/2025 at 10:04 A.M., Resident 33 was observed to have a large amount of hair on her chin and upper lip. A record review was completed for Resident 33 on 5/21/2025 at 2:46 P.M. Diagnoses included, but were not limited to: moderate protein calorie malnutrition, anxiety and depression. A Quarterly MDS (Minimum Data Set), dated 5/6/2025 indicated Resident 33's cognition was intact and she required setup and cleanup assistance from staff with personal hygiene. During an interview, on 5/22/2025 at 8:24 A.M., Resident 33 indicated she did not want anyone helping her with her facial hair and she would take care of it when she wanted to. During an interview, on 5/22/2025 at 9:10 A.M., LPN 11 indicated she had asked the resident if she could shave her facial hair in the past and the resident always refused. During an interview, on 5/22/2025 at 10:34 A.M., CNA 15 indicated Resident 33 usually refused to have her facial hair shaved. She indicated that if the resident refused, she documented the refusal in the resident's electronic medical record. A current Care Plan, initiated on 4/13/2020 indicated the resident had the potential for a self care deficit related to requiring staff assistance with ADL's (activities of daily living) and refused showers at times. Interventions included, but were not limited to: assist with ADL's as indicated. The Care Plan lacked documentation that Resident 33 had refused when staff attempted to assist her with the removal of her facial hair. During an interview, on 5/23/2025 at 8:56 A.M., the Household's Unit Manager indicated that if the resident refused to have staff help her with removing her facial hair then it should have been documented on her care plan. On 5/23/2025 at 9:57 A.M. the Household's Unit Manager provided the policy titled, Care Plan - Care Plan Reviews, dated 7/2006 and indicated it was the policy currently being used by the facility. The policy indicated, Purpose: To maintain care plans on a current status. 1. The Care Plan team will be responsible for the periodic review and updating of care plans 3.1-35(e)

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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, record review and interview the facility failed to ensure medications were administered based on manufacturers guidelines for 1 of 5 residents reviewed for medication administration (Resident 37). Finding includes: During an observation of medication administration on 5/21/2025 at 11:53 A.M., LPN 9 administered one omeprazole 20 mg (milligrams) delayed release capsule by mouth to Resident 37. During the time of administration, Resident 37 had been sitting in the dining room and had already eaten most of his lunch. A record review was completed for Resident 37 on 5/21/2025 at 2:07 P.M. Diagnoses included, but were not limited to: gastro-esophageal reflux disease. A Physician's Order, initiated on 2/21/2025 indicated the resident was to receive omeprazole 20 mg delayed release tablet every day at noon. During an interview, on 5/22/2025 at 11:19 A.M., the (Pharmacy Name) Pharmacist indicated, ideally the omeprazole 20 mg delayed release capsule should have been given prior to the resident's first meal of the day. On 5/22/2025 at 1:30 P.M. the ADON provided the medication information sheet titled, Omeprazole Delayed-Release Capsules and Tablets, no date. The medication information sheet indicated, Take this drug before meals On 5/23/2025 at 11:08 A.M., the DON provided the policy titled, Medication Administration, dated 12/13/2024 and indicated it was the policy currently being used by the facility. The policy indicated, 17. Administer medication as ordered in accordance with manufacturer specifications. a. Provide appropriate amount of food and fluid 3.1-48(c)(2)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to ensure a resident who was at risk for pressure ulcers did not develop a stage II pressure ulcer and failed to implement a treatment for 1 of 2 residents reviewed for pressure ulcers. (Resident 94) Finding includes: During an interview, on 5/21/2025 at 9:19 A.M., CNA 18 indicated she thought Residnet 94 had a very small area on his bottom last week. She indicated it's an independence thing with him. He always wants to stay in his wheelchair because he knows he can go whenever he wants to. She indicated therapy had been working with him on self-transfers in and out of bed. During an observation, on 5/21/2025 at 9:26 A.M., Resident 94 was assisted to the bathroom where he was able to stand upright while holding onto the toilet seat riser bars. The aide pulled his pants down and Resident 94 had an opened area to the left inner buttock cheek. The area was approxamately a half inch in diameter with red colored tissue to the center of the wound. No dressing was observed covering the area. The record for Resident 94 was completed on 5/21/2025 at 9:37 A.M. Diagnoses included, but were not limited to chronic kidney disease, hemiplegia, insomnia, low back pain, restless leg syndrome and venous insufficiency. Resident 94's Physician Orders included: Weekly Skin Check. Complete head to toe assessment of skin. Document findings in Skin Condition tab. Re-evaluate and update existing skin concerns. If new conditions are found, initiate the Skin Condition Checklist. A Braden Scale for Predicting Pressure Sore Risk assessment, dated 1/14/2025, indicated Resident 94's score totaled 15, which meant he was at risk for pressure ulcer/injury developement. A Braden Scale for Predicting Pressure Sore Risk assessment, dated 4/8/2025, indicated Resident 94's score totaled 17, which meant he was at risk for pressure ulcer/injury developement. A current Care Plan, initiated on 2/16/2024, indicated the resident had the potential for or actual skin impairment related to venous insufficiency, end stage chronic kidney disease, right hemiplegia and frail skin that tears easily. Interventions included but were not limited to: Observe resident's skin daily with care. Report any changes in skin integrity to nurse. Encourage/assist with frequent position changes if a resident is sitting or lying in the same position for extended periods of time. A current Care Plan, initiated on 2/16/2024, indicated the resident had impaired physical mobility related to end stage renal failure, bursitis, cellulitis, neck pain, low back pain, right side hemiplegia, venous insufficiency. Interventions included but were not limited to assisting with ADL's (activities of daily living) as directed. staff to assist as needed with bed mobility, transfers and toileting and assist/encourage resident to participate with ADL tasks. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current Care Plan, initiated on 2/16/2024, indicated a plan to address the resident's risk for skin impairment. The goal was for the resident's skin to remain clean, dry and free of breakdown related to incontinence. Interventions included but were not limited to: Perineal cleansing and apply protective skin barrier after each incontinent episode. Assess and report signs of impaired skin integrity or breakdown. A current Care Plan, initiated on 5/21/2024, indicated Resident 94 was at risk for further impaired skin integrity related to impaired mobility, moisture, history of pressure ulcers and cellulitis. Interventions included but were not limited to alternating air loss mattress, pressure reducing cushion for his wheelchair, treatments as ordered and offer peri care after incontinent episodes and every shift. During an interview, on 5/21/2025 at 10:33 A.M., RN 19 indicated she thought she had been previously notified of the open area on Resident's 94 left buttock cheek. RN 19 was questioned about the procedure when a new skin issue was observed to a resident. RN 19 indicated the area was to be measured, a skin incident report needed to be completed and entered into the computer, and the physician, family and facility management were to be notified of the open area. RN 19 indicated there was no Skin Incident assessment completeed and no current treatment order for Resident 94's open area. She indicated there should have been a Skin Incident, a treatment order in place and care plan initiated for the new open area. During the interview, on 5/21/2025, RN 19 was questioned regarding the timing of when weekly skin assessments were completed by the nurses. RN 19 indicated the weekly skin assessments were documented on the shower sheets. Resident 94's Shower Sheet/Skin Check sheets for May 2025 had been completed on 5/1 and 5/15/2025 with no open area observed to the left buttocks documented on either form. A Shower Sheet/Skin Check sheet, completed on 5/22/2025, after the observation and interview with RN 19 confirming the open area, indicated the resident's skin was intact, no ulcers/open wounds but yes was checked for reddened area. A Skin Evaluation Form, dated 5/6/2025, indicated General skin check completed-existing wounds noted no changes.The following was marked - Pressure reduction bed: Not applicable. Preventative Protective Skincare: Not applicable. Turning/ Repositioning Program: Not applicable. A Skin Evaluation Form, dated 5/12/2025, indicated General skin check completed indicated the following was marked- No new issues. Pressure reduction bed: Not applicable. Preventative Protective Skincare: Not applicable. Turning /Repositioning Program: Not applicable. A Skin Evaluation Form, dated 5/19/2025, indicated General skin check completed. No new issues. The following was marked - Pressure reduction bed: Inapplicable. Preventative Protective Skincare: In applicable. Turning/Repositioning Program: Inapplicable. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse's Progress Note, dated 5/21/2025 at 1:14 P.M., indicated RN 19 had assessed an open area on Resident 94's left buttock. The area was not on a bony prominence. The area measured 0.5 cm x 1.0 cm. The note indicated the nurse had applied [NAME] oxide and had notified the physician, family and facility management. During an interview, on 5/21/2025 at 2:05 P.M., Resident 94 indicated he was given a shower last Thursday, 5/15/2025, or Friday, 5/16/2025. He indicated hospice had previously been completing his showers, three times a week and since the facility had been giving his showers, he received them two times a week. Resident 94 indicated the facility was having trouble getting them (showers) started again. He indicated that his buttocks hurt. When questioned what type of pain, he indicated it was a continuous severe achy pain." In addition, Resident 94 indicated, it hurts unless I get moved. He indicated that I try to shift and get off of it, but I can't get it done. When asked if the aides come in and stand him up or move him in his wheelchair, he stated When I pulled the cord (call light) and ask them to do it, the aides seldom do it. They say 'we have to get a nurse.' They have never changed my position. Resident 94 indicated he had not refused any showers. During an observation, on 5/22/2025 at 3:40 P.M., Resident 94's gel cushion for his wheelchair was almost flat in the middle where his buttocks was positioned. During an interview, on 5/22/2025 at 3:49 P.M., the unit manager indicated the cushion should have been changed. He was unsure if it was a pressure reduction or a pressure relieving device. He indicated the residnet should not have been sitting on the flattened cushion. On 5/23/2025 at 11:29 A.M., the Director of Nursing provided the policy titled, Pressure Injury Prevention and Management, dated 2/26/2024, and indicated the policy was the one currently used by the facility. The policy indicated . Avoidable means that the resident developed a pressure ulcer/injury and that the campus did not do one or more of the following: evaluate the residents clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards it practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate . Interventions for Prevention and to Promote Healing. a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions . c. Evidenced-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: I. Redistribute pressure (such as repositioning, protecting/or offloading heels, etc.) . c. Provide appropriate, pressure -redistributing, support surfaces . 3.1-40

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review and interview, the facility failed to ensure a safe smoking assessment was completed, smoking materials were locked up and safe disposal of cigarette butts was designated for 1 of 1 resident reviewed for accidents and hazards. (Resident 73) Finding includes: During an observation, on 5/20/2025 at 10:50 A.M., Resident 73 was observed taking himself out of the building to smoke. He was observed on the sidewalk of the facility between South 13th Street and the main entrance. During an observation, on 5/22/2025 at 8:59 A.M.-9:24 A.M., Resident 73 was observed outside smoking. He smoked three cigarettes and was observed putting the cigarette out on his wheelchair by the front wheel and held the smoked cigarette butts in his hand. During an observation, on 5/22/2025 at 2:06 P.M., Resident 73 was in his room. His cigarettes and lighter were lying inside his hat on a table in his room. During an observation, on 5/23/2025 at 9:02 A.M., Resident 73 was observed outside smoking on the facility campus. A record review for Resident 73 was completed, on 5/21/2025 at 9:55 A.M. Diagnoses included, but were not limited to: polyneuropathy, glaucoma, diabetes mellitus type 2 and nicotine dependence. A Quarterly Minimum Data Set (MDS) assessment, dated 3/12/2025, indicated Resident 73 was cognitively intact and used a motorized wheelchair. A Physician's Order, dated 12/18/2024, indicated to educate Resident 73 on the risks of smoking and document in the interdisciplinary notes every shift and smoking paraphernalia was to be placed in a lock box while inside the building. A Care Plan, initated on 1/10/2023 and revised on 1/6/2025, indicated Resident 73 would use nicotine in a safe way and in the designated area. Interventions included, but were not limited to: Resident 73 was aware of the designated area to smoke and to check in with staff before leaving, encouraged to store smoking material in nurses' carts, but declined, a lock box was provided in the room for smoking material and Resident 73 had declined to sign the facility smoking assessment. A Safe Smoking Assessment was not completed and signed by the resident until 5/21/2025. During an interview, on 5/22/2025 at 2:06 P.M., Resident 73 indicated he went outside on his own and always had his cigarettes on him. He indicated he did not throw his cigarette butts on the ground, and sometimes he knocked off the cherry (lighted end of cigarette) and threw the butts in the trash can in his room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 5/23/2025 at 11:47 A.M., QMA 21 indicated Resident 73 was not to smoke on the campus and he was to go across the street to smoke. She indicated Resident 73 did not need supervised and she was unsure where he disposed of his cigarette butts. During an interview, on 5/23/2025 at 1:13 P.M., LPN 3 indicated the facility was a non-smoking campus and Resident 73 chose to cross the road to smoke his cigarettes. She was not sure if Resident 73 placed his cigarette butts in his trash can in his room. During an interview, on 5/23/2025 at 1:16 P.M., the Director of Nursing (DON) indicated the facility was a non-smoking campus. She indicated Resident 73 adamantly refused to sign the safe smoking assessment until he thought the Social Service Director would get in trouble because he had not signed the assessment. The DON indicated the facility staff continually educated Resident 73 for interventions related to his smoking habits. During an interview, on 5/23/2025 at 2:03 P.M., the Social Service Director indicated there were no previously completed safe smoking assessments found in the medical record. A policy was provided, on 5/23/2025 at 1:03 P.M. by the DON. The policy titled, Smoking Policy, indicated, .It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents .1. Smoking is prohibited in all areas except the designated smoking area. A 'Designated Smoking Area sign will be prominently posted .2. Safety measures for the designated smoking area will include, but not limited to: a. protection from weather conditions [i.e. covered]. b. Provision of ashtrays made of noncombustible material and safe design .4. All residents and family members will be notified of this policy during the admission process, and as needed. 5. All residents will be asked about tobacco use during the admission process, and during each quarterly or comprehensive MDS assessment process. 6. Residents who smoke will be further assessed using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all .12. If a resident or family does not abide by the smoking policy or care plan [e.g. smoking materials are provided directly to the resident, smoking in non-smoking areas, does not wear protective gear], the plan of care may be revised to include additional safety measures 3.1-45(a)(1)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, record review and interview, the facility failed to provide identified interventions to promote consumption of meals for 1 of 3 residents reviewed for nutrition. (Resident 31) Finding includes: A record review for Resident 31 was completed on 5/21/2025 at 9:12 A.M. Diagnoses included, but were not limited to: cerebral infarction, dysphagia and hemiplegia of the left side. A Significant Change Minimum Data Set (MDS) assessment, dated 2/22/2025, indicated Resident 31 had severe cognitive impairment, required mechanically altered foods and had impairment to the upper and lower extremity on one side. A review of Resident 31's weights indicated the following: -5/19/2025 1:54 P.M. 108.4 pounds -4/15/2025 9:11 A.M. 116.0 pounds -2/18/2025 9:20 P.M. 125.2 pounds -11/25/2024 3:04 P.M. 131.0 pounds The weights reviewed indicated a 6.55 percent weight loss in one month, a 13.42 percent weight loss in three months and a 15.31 percent weight loss in months. A Nursing Progress Note, on 5/13/2025 at 8:05 A.M., indicated Resident 31 appeared to be overwhelmed by plates of food. The staff had suggested serving one item in a bowl at a time with each bowl introduced as tolerated. The suggestion was reviewed with [NAME] 22 and [NAME] 22 indicated she would share the suggestion with the facility staff. A Care Plan, dated 2/27/2025, indicated Resident 31 was at risk for malnutrition and weight changes related to a recent hospitalization with cerebral infarction with left hemiplegia and her weight had decreased significantly in the past month. Interventions included, but were not limited to: a mechanically soft diet, encouragement to eat at mealtimes, provide assistance as needed to consume meals, serve half servings of one food in a bowl at a time, offer the next bowl and big plates of food were overwhelming. During an observation, on 5/21/2025 at 11:57 A.M., Resident 31 was in the dining room with a plate of noodles and mashed potatoes with gravy in front of her. During an observation, on 5/22/2025 at 12:03 P.M., Resident 31 had eaten in her room with a plate of beets and quiche in front of her. Resident 31 had asked what she should do with the food. During an observation, on 5/23/2025 at 9:09 A.M., Resident 31 had a breakfast tray in front of her with various liquids, a bowl of cornflakes and a cup pf yogurt. She had been sleeping and had not eaten her food. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 5/23/2025 at 1:05 P.M., CNA 6 indicated Resident 31's food should be as fun as it could be. During an interview, on 5/23/2025 at 1:07 P.M., QMA 2 indicated Resident 31 should be served small portions in individual bowls. A policy was provided on, 5/23/2025 at 1:00 P.M., by the DON. The policy titled, Weigh Loss/Gain Interventions, indicated, .To identify nutritionally at-risk residents and indicate corresponding interventions to monitor, communicate, and correct weight loss or gain .5. Weight loss or gain interventions shall be addressed on the resident's plan of care 3.1-(a)(1)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on record review and interview, the facility failed to follow and administer physician ordered hydration orders for 1 of 1 resident reviewed for tube feeding. (Resident 52) Finding includes: A record review for Resident 52 was completed on 5/21/2025 at 1:04 P.M. Diagnoses included, but were not limited to: functional quadriplegic, adult failure to thrive and protein-calorie malnutrition. A Quarterly Minimum Data Set (MDS) assessment, dated 5/6/2025, indicated Resident 52 had moderate cognitive impairment and received tube feeding with 51 percent of calories from the feedings and 501 cc/day (cubic centimeter per day or equal to one milliliter per day) or more of hydration from the feeding tube. A Physician's Order, dated 3/1/2024, indicated flushing the feeding tube with 120 mL (milliliters) before and after Jevity feedings, totaling a 240 mL flush. A Physician's Order, dated 3/13/2024, indicated Jevity 1.5 tube feeding two cartons (474 mL) daily and Jevity 1.5 tube feeding one carton (237 mL) three times daily. The May 2025 Medication Administration Record (MAR) indicated Resident 52 received the following water flushes below or above the ordered flush orders: -5/1/2025 8:00 A.M. 100 mL -5/1/2025 4:00 P.M. 120 mL -5/1/2025 12:00 P.M. 100 mL -5/1/2025 8:00 P.M. 120 mL -5/2/2025 8:00 A.M. 120 mL -5/3/2025 8:00 A.M. 300 mL -5/4/2025 8:00 A.M. 400 mL -5/5/2025 8:00 P.M. 100 mL -5/6/2025 8:00 A.M. 325 mL -5/8/2025 8:00 A.M. 350 mL -5/9/2025 8:00 A.M. 350 mL -5/10/2025 12:00 P.M. 120 mL (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/12/2025 8:00 P.M. 100 mL -5/13/2025 8:00 A.M. 350 mL -5/13/2025 8:00 P.M. 100 mL -5/14/2025 8:00 P.M. 100 mL -5/15/2025 8:00 P.M. 100 mL -5/17/2025 8:00 A.M. 350 mL -5/18/2025 8:00 A.M. 350 mL -5/20/2025 8:00 A.M. 300 mL -5/22/2035 8:00 A.M. 350 mL -5/22/2025 8:00 P.M. 120 mL -5/23/2025 8:00 A.M. 100 mL -5/23/2025 12:00 P.M. 100 mL A Care Plan, dated 3/5/2023, indicated Resident 52 had a feeding tube necessary for nutritional needs related to swallowing difficulties and a nothing by mouth order. Interventions included, but were not limited to: provide tube feeding and nutritional supplements as ordered, give 120 mL of water before and after each feeding, and monitor for signs of dehydration. During an interview, on 5/23/2025 at 9:18 A.M., LPN 3 indicated Resident 52 should have received 120 mL of water before and after his Jevity tube feedings. She indicated the amount of water provided was documented in the MAR. The MAR lacked documentation of the correct amount of water flushes/hydration being provided before and after feedings and the daily totals were incorrect. A policy was provided on, 5/23/2025 at 1:00 P.M., by the DON. The policy titled, Care and Treatment of Feeding Tubes, indicated, .It is the policy of this campus to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible .4. The campus will utilize a Registered Dietician in estimating and calculating a resident's daily nutritional and hydration needs .7. Direction for team member[s] on how to provide the following care will be provided: .e. Frequency of and volume used for flushing, including flushing medication administration, and what to do when a prescriber's order does not specify 3.1-46(b)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review and interview, the facility failed to store respiratory equipment in a sanitary manner for 1 of 2 residents reviewed for respiratory care. (Resident 66) Finding includes: During an observation, on 5/19/2025 at 10:45 A.M., Resident 66's nebulizer mask and tubing had not been dated or bagged, and the dirty mask with white colored specs of dried debris was laying on the bed side table. During an observation, on 5/21/2025 at 9:10 A.M., Resident 66's nebulizer mask and tubing had not been dated or bagged, and the dirty mask with white colored specs of dried debris remained on the bedside table. During an observation, on 5/22/2025 at 9:02 A.M., the nebulizer mask and tubing had not been dated or bagged, and the dirty mask with white colored specs of dried debris remained on the bedside table. The record for Resident 66 was reviewed on 5/21/2025 at 11:51 A.M. Diagnoses included, but were not limited to diabetes, depression, dementia, anxiety and chronic obstructive pulmonary disease. Resident 66's current Physician Orders included: Ipratropium-albuterol 0.5 mg (milligram) -3 mg (2.5 mg base)/3 ml Neb Solution 1 ml inhalation every 6 hours as needed for cough and congestion. There were no physician's order specific to changing the nebulizer mark or tubing. During an interview, on 5/22/2025 at 9:17 A.M., RN 19 indicated the nebulizer mask should have been stored in a bag when it was not in use and should have been dated to indicate when the mask and/or tubing had been changed. On 5/23/2025 at 11:29 A.M., the Director of Nursing provided the policy titled, Oxygen Therapy-Nebulizer Treatment, dated 1/2016, and indicated the policy was the one currently used by the facility. The policy indicated .6. After treatment, remove mask, disassemble nebulizer set, rinse and place clean nebulizer set in plastic bag . 9. Tubing, nebulizer set, and plastic bag are changed weekly 3.1-47(a)(6)

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on record review and interview, the facility failed to provide daily fistula checks for 1 of 1 resident reviewed for dialysis. (Resident 75) Finding includes: During an interview, on 5/20/2025 at 9:28 A.M., Resident 75 indicated she received dialysis on Mondays, Wednesdays and Fridays. Resident 75's fistula access site was observed in her left bicep. A record review for Resident 75 was completed on 5/21/2025 at 2:22 P.M. Diagnoses included, but were not limited to: end stage renal disease, diabetes mellitus type 2 and anemia. An Annual Minimum Data Set (MDS) assessment, dated 4/4/2025, indicated Resident 75 was cognitively intact and received dialysis treatments. A Physician's Order, dated 7/11/2024, indicated the dialysis access site was in the left bicep. A Care Plan, dated 5/3/2024, indicated Resident 75 has end stage renal disease and required hemodialysis three times per week. Interventions included, but were not limited to: assess, observe and document care of the access site and to document in the interdisciplinary notes monitoring for complications. A review of the interdisciplinary notes and the treatment/medication administration records had no documentation of the fistula site having been accessed on a daily or shift basis. During an interview, on 5/22/2025 at 2:11 P.M., RN 7 indicated the fistula access site was only monitored on Resident 75's dialysis days and assessments were not completed on the non-dialysis days. A policy was provided on, 5/23/2025 at 1:00 P.M., by the DON. The policy titled, Hemodialysis, indicated, . This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis . 14. The nurse will ensure that the dialysis access site is checked before and after dialysis treatments and every shift for patency by auscultation for a bruit and palpating a thrill 3.1-47

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155205	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greencroft Healthcare	1225 Greencroft Dr Goshen, IN 46527

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 8. During an observation in Resident 94's bathroom, on 5/21/2025 at 2:50 P.M., there was a small bottle sitting on the sink counter. The container had a label indicating it was nystatin powder for the residents' abdominal folds. The record for Resident 94 was completed on 5/21/2025 at 3:16 P.M. Diagnoses included but were not limited to hypertension, hemiplegia, anxiety, depression, and renal insufficiency. Current Physician Orders included 100,000 unit/gram topical powder-apply topical twice a day (BID) as needed for rash and redness in abdominal folds. During an observation of Resident 94's bathroom, on 5/22/2525 at 3:33 P.M., the Nystatin bottle remained on the counter in the bathroom. During an interview, on 5/22/2025 at 3:35 P.M., the Households Unit manager indicated the nystatin should not have been in the residents' room. On 5/23/2025 at 11:08 A.M., the DON provided the policy titled, Labeling of Medications and Biological's, dated 4/13/2024 and indicated it was the policy currently being used by the facility. The policy indicated, Policy: All medications and biological's used in the campus will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. 1. All medications and biological's will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles 3.1-25(m) Based on observation, interview and record review the facility failed to ensure medications were not left unattended in resident rooms (Resident 94), failed to ensure medications were labeled and dated when opened and failed to ensure expired medications were properly disposed of in 5 of 6 medication carts reviewed and 2 of 3 medication rooms reviewed. ([NAME], Oasis, [NAME], [NAME] and Vista medication carts and [NAME] and Vista medication rooms). Findings include: 1. During a medication storage observation, on 5/21/2025 at 9:13 A.M., on the Oasis medication cart with QMA 10, the following was observed: - six opened bottles of polyethylene glycol with no open date. During an interview, on 05/21/2025 at 9:18 A.M., QMA 10 indicated the opened bottles of polyethylene glycol should have been dated when opened. 2. During a medication storage observation, on 5/5/2025 at 11:02 A.M., on the [NAME] medication cart with LPN 11, the following was observed: (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An opened bottle of meclizine 25 mg chewable tablets with no open date. - An opened bottle of risiquad 2 30 mg capsules with no open date. - An opened bottle of Centrum Silver tablets with no open date. - An opened bottle of polyethylene glycol with no open date. During an interview, on 5/21/2025 at 9:26 A.M., LPN 11 indicated the opened bottles of medications should have had open dates. 3. During a medication storage observation, on 5/22/2025 at 9:25 A.M., on the [NAME] medication cart with LPN 12, the following was observed: - An opened bottle of gas relief chews 25 mg with no open date. - An opened bottle of omega 3 1000 mg capsules with no open date. During an interview, on 5/22/2025 at 9:35 A.M., LPN 12 indicated the opened medications should have been dated when opened. 4. During a medication storage observation, on 5/23/2025 at 9:06 A.M., on the Vista medication cart with LPN 12, the following was observed: - An opened Breo Ellipta inhaler with no open date. During an interview, on 5/23/2025 at 9:09 A.M., LPN 12 indicated the Breo Ellipta inhaler should have been dated when opened. 5. During a medication storage observation of the Vista medication room, on 5/23/2025 at 9:10 A.M. with LPN 12, the following was observed: - 19 packages of povidone iodine swabs with an expiration date of 4/2025. During an interview, on 5/23/2025 at 9:16 A.M., LPN 12 indicated the expired povidone iodine swabs should have been thrown away. 6. During a medication storage observation of the [NAME] medication room, on 5/23/2025 at 9:22 A.M. with QMA 13, the following was observed: - four boxes of probe covers with an expiration date of 3/31/2025. During an interview, on 5/23/2025 at 9:29 A.M. QMA 13 indicated the probe covers should have been thrown away. 7. During a medication storage observation, on 5/23/2025 at 11:33 A.M., of the [NAME] medication cart with LPN 14, the following was observed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An opened bottle of flaxseed oil 1000 mg with no open date. During an interview, on 5/23/2025 at 11:37 A.M., LPN 14 indicated the opened flaxseed oil should have been dated when opened.

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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, record review and interview, the facility failed to provide enhanced barrier precautions for 1 of 2 residents reviewed for urinary catheters. (Resident 36) Finding includes: During an interview, on 5/19/2025 at 1:47 P.M., Resident 36's wife indicated Resident 36 had a suprapubic catheter and had had the urinary catheter for the past two and a half years. A record review for Resident 36 was completed on 5/21/2025. Diagnoses included, but were not limited to: retention of urine and pressure ulcer of sacral region. A Significant Change Minimum Data Set (MDS) assessment, dated 4/22/2025, indicted Resident 36 had severe cognitive impairment, had an indwelling urinary catheter, had an unstageable pressure ulcer and received hospice services. A Physician's Order, dated 5/23/2024, indicated enhanced barrier precautions (EBP) every shift for a suprapubic catheter. A Care Plan, dated 5/24/2024, indicated Resident 36 required enhanced barrier precautions for an indwelling medical device and a pressure ulcer to the sacral region. Interventions included, but were not limited to: implement and follow EBP during high-contact resident care activities as ordered (gown and glove use) and educate family/representative as needed. During an observation, on 5/22/2025 at 1:48 P.M., CNA 4 and CNA 5 were observed providing incontinent care in Resident 36's room without wearing gowns. During an interview, on 5/22/2025 at 1:48 P.M., CNA 5 indicated Resident 36 was on EBP and they should have been wearing personal protective equipment (PPE) for Resident 36's care. A policy was provided on, 5/23/2025 at 1:00 P.M., by the DON. The policy titled, Enhanced Barrier Precautions, indicated, .It is the policy of this community to implement enhanced barrier precautions for the prevention of transmission of multi-drug resistant organisms .2. Initiation of Enhanced Barrier Precautions .b. An order for enhanced barrier precautions will be obtained for residents with the following: wounds . indwelling medical devices .even if the resident is not known to be infected or colonized with a MDRO [multi-drug resistant organism] .3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room .b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities .4. High-contact resident care activities include: e. changing linens, f. Changing briefs or assisting with toileting 3.1-18(b)