STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Lakes Healthcare Center	2300 Great Lakes Dr Dyer, IN 46311

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 20580 Based on observation, record review, and interview, the facility failed to meet residents' needs related to a call light not placed within reach for 2 of 7 residents observed for call light placement. (Residents G and K) Findings include: 1. During an observation on 4/22/24 at 9:52 a.m., Resident G was lying in bed with the head of the bed up and his breakfast tray sitting in front of him on the over the bed table. The call light was draped over the bedside dresser on the right side of the bed and was out of reach of the resident. During an observation on 4/22/24 at 10 a.m., CNA 3 and CNA 4 entered the room, and removed the meal tray. The call light remained draped over the bedside dresser. During an observation on 4/22/24 at 10:10 a.m., the call light remained draped over the bedside dresser. During an observation on 4/22/24 at 10:22 a.m., CNA 3 and CNA 4 entered the room. They indicated they had been checking on the resident every one to two hours. After repositioning the resident, CNA 4 placed the call light within reach of the resident. CNA 3 indicated at the time of the observation the resident would not have been able to reach the call light when it was draped over the bedside dresser. Resident G's record was reviewed on 4/22/24 at 11:54 a.m. The diagnoses included, but were not limited to, cerebrovascular insufficiency and dementia. A Quarterly Minimum Data Set assessment, dated 2/12/24, indicated a moderately impaired cognitive status, impairment of the bilateral lower extremities, was dependent for bed mobility and transfers, and has had a history of falls and one fall since the last assessment. A Care Plan, revised on 2/1/24, indicated a risk for falls and actual falls had occurred. An intervention, dated 8/14/23, indicated the call light would be within reach of the resident. 2. During an observation on 4/22/24 at 9:42 a.m., Resident K was lying in bed with her eyes closed. The breakfast tray was on the over the bed table in front of her. The call light was tied to the side rail, and hanging down toward the floor and not within reach for the resident. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/22/24 at 10:12 a.m., the meal tray had been removed. The head of the bed remained elevated. The call light continued to be out of reach from the resident and was hanging down from the side rail on the bed. During an observation on 4/22/24 at 10:34 a.m., Resident K received incontinent care by CNA 5. The call light was placed within reach to the resident. This citation is related to Complaints IN00429320 and IN00429834. 3.1-35(b)(1)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on record review and interview, the facility failed to notify the resident and/or the resident's Responsible Party in writing of an intrafacility transfer related to changing rooms due to a COVID-19 outbreak for 3 of 3 residents reviewed for infection control. (Residents D, M, N) Findings include: 1. During an interview on 4/22/24 at 11:14 a.m., Resident D indicated he was moved to a different room when he had COVID-19. He was in the other room for 20 days and they kept telling him he was going to move back tomorrow. The record for Resident D was reviewed on 4/22/24 at 12:18 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease) hemiplegia, stroke, heart failure, venous insufficiency, vascular dementia, anxiety disorder, and chronic kidney disease. The Quarterly Minimum Data Set (MDS) assessment, dated 2/16/24, indicated the resident was cognitively intact for daily decision making. Nurses' Notes, dated 3/20/24 at 11:33 a.m., indicated the resident had tested positive for COVID-19 that morning. Nurses' Notes, dated 3/20/24 at 11:34 a.m., indicated the resident and Guardian were made aware of the room change and had no questions or concerns at the time. The resident was transferred back to the original room on 4/7/24. There was no documentation regarding the move back in the clinical record. There was no documentation of an intrafacility transfer form for the move to another room when the resident had tested positive for COVID-19. During an interview on 4/22/24 at 3:15 p.m., the Director of Nursing indicated there was no intrafacility transfer form for the resident when he had moved to a different room when he tested positive for COVID-19. 32788 2. The record for Resident M was reviewed on 4/23/24 at 9:10 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and chronic kidney disease. The Quarterly Minimum Data Set (MDS) assessment, dated 4/12/24, indicated the resident had impaired short term and long term memory and severely impaired cognitive decision making skills. A Progress Note, dated 3/15/24 at 12:58 p.m., indicated the resident had tested positive for COVID-19, was on droplet isolation precautions, and was to reside on the quarantine unit in a room alone. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The census tab of the chart indicated the resident was moved from room [ROOM NUMBER] B to room [ROOM NUMBER] A on 3/15/24. The was a lack of an intra-facility transfer form or documentation of a room change notification. During an interview with the Social Service Director on 4/23/24 at 11:07 a.m., she indicated she had not completed a notification of room change form. The resident had changed rooms due to being COVID positive. 3. The record for Resident N was reviewed on 4/23/24 at 9:10 a.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation, and coronary artery disease. The Annual Minimum Data Set (MDS) assessment, dated 4/8/24, indicated the resident was cognitively intact. A Progress Note, dated 3/15/24 at 12:57 p.m., indicated the resident had tested positive for COVID-19, was on droplet isolation precautions, and was to reside on the quarantine unit in a room alone. The census tab of the chart indicated the resident was moved from room [ROOM NUMBER] A to room [ROOM NUMBER] A on 3/15/24. The was a lack of an intra-facility transfer form or documentation of a room change notification. During an interview with the Social Service Director on 4/23/24 at 11:07 a.m., she indicated she had not completed a notification of room change form. The resident had changed rooms due to being COVID positive. This citation relates to Complaint IN00430986. 3.1-3(v)(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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 20580 Based on observation and interview, the facility failed to ensure a clean and homelike environment, related to stained, dirty, and tattered bed linens for 3 of 6 residents reviewed for a homelike environment. (Residents D, C, and H) Findings include: 1. During an observation on 4/22/24 at 11:14 a.m., Resident D was sitting up in a wheelchair at the bedside. He had requested to be transferred back to bed after his bed was made. His bed had been stripped and two CNAs entered the room and made the bed. There was a hole in the bottom sheet that had been placed on the bed. The CNAs transferred the resident to bed after the bed was made and left the room. During an observation on 4/23/24 at 10:10 a.m., the bottom sheet with hole in the sheet remained on the resident's bed. 2. During an observation on 4/22/24 at 3:48 p.m., Resident J was lying in bed with the head of the bed slightly elevated. There were two pillows under the resident's head. There was a brownish/tan dried stain on the pillow case of the bottom pillow. 3. During an observation on 4/23/24 at 7:55 a.m., Resident C was lying in bed with the head of the bed elevated. There was an orange stain on the pillow case under her head. Resident C indicated she would like to be repositioned in bed and activated the call light. Wound Nurse 1 and the Unit Manager entered the room and began to reposition the resident. When the pillow was removed from under the right leg, a dried tan stain was observed on the pillow case. Wound Nurse 1 indicated the dressing on the right lower leg was intact and she was unsure what the dried tan stain was from. They turned the resident to the right side. An incontinent brief was worn by the resident and intact. The pressure dressing and wound vacuum dressings on the buttocks were intact. There were large dried beige stains on the bottom sheet under the resident. The Unit Manager indicated the staff had not been in the room for the morning care yet. No further information was received from the Unit Manger when asked if the sheets should have been changed during the night when they repositioned and checked the resident. During an interview with the resident at the time of the observation, she indicated no one had been her room all night. During an interview on 4/23/24 at 8:25 a.m., the Administrator indicated if the linens were soiled, they should have been changed. During an interview on 4/23/24 at 1:20 p.m., the Administrator indicated the facility has ordered 16 dozen new sheets, both tops and fitted. If the linen was tattered, they were to be thrown out and replaced, as there was plenty of linen to replace the stained and tattered linen. This citation relates to Complaints IN00429320 and IN00429834. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-19(f)(5) 3.1-19(g)(4)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 10770 Based on record review and interview, the facility failed to ensure a recapitulation of the resident's stay was documented on the discharge summary provided to the resident at the time of discharge for 3 of 3 residents reviewed for discharge. (Residents B, E, and F) Findings include: 1. The record for Resident B was reviewed on 4/22/24 at 9:53 a.m. Diagnoses included, but were not limited to, high blood pressure, atrial fibrillation, heart disease, heart failure, adult failure to thrive, hallucinations, and anemia. The Modification of the Quarterly Minimum Data Set (MDS) assessment, dated 1/10/24, indicated the resident was moderately impaired for daily decision making. Physician's Orders, dated 3/21/22, indicated may discharge to an assisted living facility on 3/22/24. The Discharge Summary, dated 3/19/24, indicated the Course of illness/Progress (include any complications experienced) had N/A documented in the space. There was no documentation of a recapitulation of the resident's stay on the discharge summary. During an interview on 4/22/24 at 3:25 p.m., the Director of Nursing indicated she was unaware the nursing staff were documenting N/A under the course of stay. The Discharge Summary was to be completed and was given to the resident at the time of discharge. 2. The record for Resident E was reviewed on 4/22/24 at 10:53 a.m. Diagnoses included, but were not limited to, fracture of the left radius, high blood pressure, uterine cancer, and major depressive disorder. The resident was discharged to an assisted living facility on 4/19/24. The Admission Minimum Data Set (MDS) assessment, dated 4/2/24, indicated the resident was moderately impaired for decision making. Physician's Orders, dated 4/17/24, indicated may discharge to assistant living facility on Friday 4/19/24. The Discharge Summary, dated 4/15/24, indicated the Course of illness/Progress (include any complications experienced) had N/A documented in the space. There was no documentation of a recapitulation of the resident's stay on the discharge summary. There was no documentation in Nursing Progress Notes at the time of discharge on 4/19/24. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/24 at 3:25 p.m., the Director of Nursing indicated she was unaware the nursing staff were documenting N/A under the course of stay. The Discharge Summary was to be completed and was given to the resident at the time of discharge. There was no documentation in Nursing Notes at the time the resident discharged . 3. The record for Resident F was reviewed on 4/22/24 at 11:14 a.m. Diagnoses included, but were not limited to, fracture lower leg, high blood pressure, depressive disorder, and mild intellectual disabilities. The Admission Minimum Data Set (MDS) assessment, dated 1/29/24, indicated the resident was cognitively impaired for daily decision making. Physician's Orders, dated 3/11/24, indicated may discharge home on Wednesday 3/13/24 with home health. The Discharge Summary, dated 3/11/24, indicated the Nursing section where the Course of illness/Progress (include any complications experienced) was located was blank and not completed. During an interview on 4/22/24 at 3:25 p.m., the Director of Nursing indicated the Discharge Summary was to be completed at the time of discharge and given to the resident. The current and undated Transfer and Discharge policy, provided by the Administrator on 4/23/24 at 10:51 a.m., indicated when a resident was discharged to home, assisted living, or another long term care facility was anticipated, the facility will develop a discharge summary that included, but was not limited to, the following: Summary of Stay-a summary of the resident's stay that included diagnosis, course of illness/treatment or therapy, pertinent labs, radiology, and consultation results. , This citation refers to Complaint IN00428543 3.1-36(a)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure residents who were dependent and/or required assistance with activities of daily living (ADL's) received assistance with their meals, for 2 of 6 residents reviewed for ADL's. (Residents L and C) Findings include: 1. During a random observation on 4/22/24 at 1:00 p.m., CNA 1 delivered a lunch tray to Resident L. The CNA placed the tray on the over bed table and left the room. At 1:13 p.m., 1:23 p.m. and 1:30 p.m., the tray remained in the same place, untouched, and the resident had not been assisted to eat. During an interview on 4/22/24 at 1:30 p.m., CNA 1 indicated she delivered the tray to the resident who was asleep at the time, and asked her if she was ready to eat. The resident told staff she was not ready to eat, so the tray was left on the over bed table. The CNA indicated she was going to check on the resident to see if she was ready to eat before she left for the day at 2:00 p.m. She was unaware that no other staff had been in the room to see if the resident was ready to eat and if she needed assistance. The record for Resident L was reviewed on 4/23/24 at 9:15 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, dysphagia, stroke, aphasia depressive disorder, anxiety disorder, bipolar disorder, sepsis, cerebral edema, and high blood pressure. A Nursing Admission Assessment, dated 4/11/24, indicated the resident was alert and oriented to person, place, and time. A Functional Abilities and Goals Assessment, dated 4/14/24, indicated the resident needed partial to moderate assistance with the task of eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal was placed before the resident). In the task section for eating, the resident was coded as being dependent for 15 meals served and independent with eating for 9 meals served. During an interview on 4/22/25 at 3:15 p.m., the Director of Nursing indicated the CNA had informed her about the time lapse of her lunch tray being in the room and that no staff had gone back into feed her. The DON indicated the CNA said she was asleep and did not want to eat at that time. During an interview on 4/23/24 at 8:00 a.m., the resident indicated she does need assistance with eating at times. 2. During an observation on 4/22/24 at 12:59 p.m., the lunch meal was delivered to Resident C's room, and placed on the shelf in the room, due to care was just being completed on the resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:02 p.m., CNA 2 offered the meal and Resident C indicated she wanted to wait until her treatments were completed before she ate her meal. Wound Nurse 1 and the Wound Nurse Practitioner then completed the treatments for the resident's pressure areas. During an observation on 4/22/24 at 2:13 p.m., Resident C was lying in bed with the head of the bed elevated. The meal tray was on her over the bed table in front of her. She had consumed the baked beans and California blend vegetable. The smoked sausage, which was approximately four inches long and a quarter size around, was untouched on the plate. Resident C indicated she wanted to eat the sausage but was unable to cut it up by herself to eat it. The Director of Nursing (DON) was interviewed immediately after the observation, and indicated she would get a staff member to come and cut the sausage up for the resident. Resident C's record was reviewed on 4/22/24 at 1:17 p.m. The diagnoses included, but were not limited to, multiple sclerosis. An Admission Minimum Data Set assessment, dated 2/21/24, indicated a moderately impaired cognitive status, no behaviors, impairment of the bilateral upper extremities, and required supervision/set-up for eating. A Care Plan, dated 2/23/24, indicated a potential for an altered nutritional status. The interventions included the staff would provide assistance with the meals as needed. This citation relates to Complaints IN00429320 and IN00429834. 3.1-38(a)(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 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. 20580 Based on observation, record review, and interview, the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services to promote healing, related to dressings not present as ordered by the Physician, for 1 of 3 residents reviewed for pressure ulcers. (Resident C) Finding includes: During an observation on 4/22/24 at 8:27 a.m., Resident C was lying in bed. CNA 2 and CNA 7 entered the room to provide repositioning and check for incontinence. The incontinent brief was undone and the resident was rolled onto her left side. The pressure area on the sacrum/coccyx area had foam inside of the area and the wound vacuum was not in place. There was no dressing covering the area. The pressure area on the left ischium had no dressing covering it, and there was no dressing on the right ischium pressure ulcer. CNA 2 indicated he started his shift at 6:30 a.m. and the resident was last checked by him, there were no dressings on the pressure wounds. CNA 7 indicated the dressings were on the resident on 4/21/24 during the day shift. During an interview on 4/22/24 at 1:02 p.m., Wound Nurse 1 and the Wound Nurse Practitioner indicated sometimes when the resident was soiled, the pressure dressings would be removed. They indicated no one had reported to them the pressure dressings were not in place. Resident C's record was reviewed on 4/22/24 at 1:17 p.m. The diagnoses included, but were not limited to, multiple sclerosis. An Admission Minimum Data Set assessment, dated 2/21/24, indicated a moderately impaired cognitive status, no behaviors, impairment of the bilateral upper and lower extremities. She required maximum assistance with toileting and bed mobility, was dependent for transfers and showers, and had an indwelling urinary catheter and was frequently incontinent of bowel movement. She was admitted into the facility with two stage four pressure ulcers (full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) and two unstageable pressure ulcers (pressure ulcer known but not stageable due to coverage of wound bed by slough and/or eschar). A Care Plan, revised on 3/27/24, indicated pressure ulcers were present. The interventions included the treatments would be completed as ordered by the Physician. The current Physician's Orders indicated the following orders for the pressure wounds treatments: - An order date of 3/2/24, indicated a wound vacuum was to be placed on the stage four pressure wounds on the sacrum and right ischium and was to be changed on Mondays, Thursdays and as needed on day shift. - An order date of 3/6/24, indicated the left ischium pressure wound was to be cleansed with wound cleanser and a hydrocolloid dressing (enhances wound healing) was to be applied on Monday, Wednesday, Friday, and as needed, on the day shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Wound Nurse Practitioner's Progress Note, dated 4/15/24, indicated: - The sacrum pressure wound was a stage four and was improving without complications. The wound measured at 5 centimeters (cm) in length by 6.3 cm in width and 1.5 cm in depth. The wound had undermining from 9 o'clock to 3 o'clock with a depth of 2.8 cm. 75-99% of the would had granulation tissue and 1-24% slough. There was moderate amount of serosanguinous drainage. - The right ischium pressure wound was a stage four and was improving without complications. The wound measured 5.3 cm in length by 4 cm in width and 0.7 cm in depth. There was 75-99% granulation tissue and 1-24% slough. There was a moderate amount of serosanguinous drainage. - The left ischium area was identified as moisture associated skin damage (MASD) and partial thickness of the skin was present. The area was improving without complications and was 100% epithelial tissue. There was a scant amount of serosanguinous drainage. During an interview on 4/23/24 at 11:24 a.m., the Director of Nursing indicated she had interviewed the CNA who worked the night shift on 4/21/24 - 4/22/24 and was informed the resident's dressings had come off during the night and she had forgotten to let the nurse know. An undated, Skin Care & Wound Management policy, received from the Administrator as current on 4/23/24 at 10:53 a.m., indicated skin care and wound management would include application of treatments and daily monitoring of the existing wounds. This citation relates to Complaints IN00429320 and IN00429834. 3.1-40(a)(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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 20580 Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, related to improper PPE (personal protective equipment) prior to providing care to a resident on enhanced barrier precautions (EBP) and hand hygiene not completed after direct resident care, for 2 of 5 residents observed for infection control practices. (Residents C and G) This had the potential to affect the residents on 2 of 3 Units (East and West) and residents who required treatment for pressure wounds. Findings include: 1. Prior to entering Resident C's room on 4/22/24 at 8:27 a.m., there was no sign on the door that indicated enhanced barrier precautions were to be used. There was a container of PPE located on the wall inside the door. During an observation on 4/22/24 at 8:27 a.m., Resident C was lying in bed. The resident had urinary catheter. CNA 2 donned gloves and unstuck the tabs on the incontinent brief. He was then stopped prior to any other care completed and asked if he should have any other special PPE on for care. CNA 2 indicated he did not need anything other than gloves on. He indicated he had not received education on enhanced barrier precautions. He then removed the gloves and left the room to go get help. No hand washing was completed upon leaving the room. CNA 2 and CNA 7 returned to the room. Hand hygiene was performed and gloves and a gown were donned from the supply located inside the door of the room. The resident's incontinent brief was undone and the resident was rolled onto her left side. The pressure area on the sacrum/coccyx area had foam inside of the area and the wound vacuum was not in place. There was no dressing covering the area. The pressure area on the left ischium had no dressing covering it, and there was no dressing on the right ischium pressure ulcer. The sheets were changed and the soiled items were placed in a plastic bag. CNA 7 completed hand hygiene after removal of the PPE. CNA 2 removed the gloves and gowns and left the room with the soiled bag without hand hygiene and walked down the hall to the Soiled Utility Room. During an observation on 4/22/24 at 1:02 p.m., the Wound Nurse Practitioner and Wound Nurse 1 entered the room for wound care treatment to be completed. Both had donned gloves and had brought supplies in for the treatment and were beginning to start the treatment when stopped prior to care started and were asked about EBP. Gowns were then donned. Wound Nurse 1 indicated she usually dons the PPE, but she was tired and forgot. Resident C's record was reviewed on 4/22/24 at 1:17 p.m. The diagnoses included, but were not limited to, multiple sclerosis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Lakes Healthcare Center	2300 Great Lakes Dr Dyer, IN 46311

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Admission Minimum Data Set assessment, dated 2/21/24, indicated a moderately impaired cognitive status, no behaviors, impairment of the bilateral upper and lower extremities. She required maximum assistance with toileting and bed mobility, was dependent for transfers and showers, and had an indwelling urinary catheter and was frequently incontinent of bowel movement. She was admitted into the facility with two stage four pressure ulcers (full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) and two unstageable pressure ulcers (pressure ulcer known but not stageable due to coverage of wound bed by slough and/or eschar). A Care Plan, dated 2/23/24, indicated an indwelling urinary catheter was present. The interventions included enhanced barrier precautions with dressing/bathing/showering/transferring/personal hygiene/changing linens/toileting/peri-care, and providing care to the urinary catheter would be used. A Care Plan, dated 2/23/24, indicated a history of vancomycin-resistant enterococcus (VRE) wound and urine infections. The interventions included enhanced barrier precautions with dressing/bathing/showering/transferring/personal hygiene/changing linens/toileting/peri-care, and providing care to the urinary catheter would be used. A Physician's Order, dated 2/22/24, indicated enhanced barrier precautions were to be used, related to an indwelling catheter and a history of or colonized multi-drug resistant organism. 2. During an observation on 4/22/24 at 10:22 a.m., Resident G was lying in bed with the head of the bed up. CNA 3 and CNA 4 entered the room. They pulled the resident up in bed by using the sheet underneath the resident. Neither CNA had donned gloves. CNA 3 then exited the room without hand hygiene and walked down the hall and retrieved a blanket from the linen closet and covered the resident with the blanket. CNA 3 then exited the room with the soiled blanket taken off the resident in his hands without placing the blanket in a plastic bag and without hand hygiene. CNA 4 completed hand hygiene upon leaving the room, using the alcohol based hand rub located outside the resident's door. During an interview on 4/22/4 at 1:30 p.m., the Director of Nursing indicated the facility educated the staff in the past week and there should be sign for the EBP and the PPE's on the resident's door. An educational training sign in form, dated 4/18/24, indicated an inservice on EBP, hand hygiene and glove usage was given to 21 nursing employees. CNA 2, CNA 3, and Wound Nurse 1 had not attended the education. 3.1-18(b)