STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Demotte	10352 N 600 E County Line Rd Demotte, IN 46310

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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 - Some	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** Based on observation, record review, and interview, the facility failed to ensure medications were stored properly, with appropriate labeling and not expired, for 2 of 2 medication carts observed and in 2 resident rooms. (ACU Cart, [NAME] Hall Cart, room [ROOM NUMBER], and room [ROOM NUMBER]) Findings include:1. On [DATE] at 10:24 a.m., the following was observed on the ACU Cart with RN 2.- A Basaglar KwikPen (insulin) was opened with no open date written on the pen. During an interview, RN 2 indicated she had used the insulin pen that day. She was unsure when it was opened, and staff should have written the open date on the insulin pen. 2. On [DATE] at 10:35 a.m., the following was observed on the [NAME] Hall Cart with LPN 1.- Lantus (insulin) vial was opened with no open date written on the vial or the box. During an interview, LPN 1 indicated she was unaware when the insulin vial had been opened. The staff should have written the open date on the insulin vial. 3. During random observations on [DATE] at 11:19 a.m., [DATE] at 9:13 a.m. and [DATE] at 8:49 a.m., an open tube of Medihoney (a topical wound treatment) and a tube of diclofenac (a topical pain medication) were observed in the bathroom of Resident room [ROOM NUMBER]. One of two residents who resided in the room used the bathroom. At that time, neither resident was prescribed Medihoney or diclofenac. 4. During random observations on [DATE] at 11:00 a.m., [DATE] at 9:15 a.m. and [DATE] at 8:24 a.m., a bag filled with saline filled syringes was observed hanging from an IV pole in room [ROOM NUMBER]. On [DATE] at 8:34 a.m., LPN 2 was observed disconnecting the IV antibiotic from the resident in room [ROOM NUMBER]. She flushed the line with one of the syringes from the bag and indicated they were all pre-filled saline syringes. During an interview on [DATE] at 3:50 p.m., the Administrator indicated she would remove the medications from the residents' rooms. A policy titled, Storage of Medications, received as current from the Corporate Nurse Consultant on [DATE] at 11:00 a.m. indicated, Medications and biologicals are stored safely, securely, and properly . The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications . When the original seal of a manufacturer's (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	container or vial is initially broken, the container or vial will be dated . The nurse shall place a date opened sticker on the medication and enter the date opened. 3.1-25(j)3.1-25(m)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review and interview, the facility failed to maintain a resident's dignity related to lack of dignity bag on a urine collection bag, wearing a hospital gown during the day, and not being fully dressed for 1 of 3 residents reviewed for dignity. (Resident 74)Finding includes:During random observations on 9/2/25 at 11:41 a.m., 9/3/25 at 10:41 a.m., 9/4/25 at 7:13 a.m., and 9/5/25 at 10:51 a.m., Resident 74 was observed resting in bed. The urine collection bag from her Foley catheter (a tube that drains the bladder) was visible from the hallway. There was no dignity bag in place. On 9/3/25 at 10:42 a.m. and 9/8/25 at 10:06 a.m., the resident was observed wearing a hospital gown.On 9/5/25 at 10:51 a.m. and 11:29 a.m., the resident was observed from the hallway. She was in bed, wearing only a shirt and disposable brief. Her brief was pulled down and her bare skin was exposed. Several staff members were observed walking past the resident's room.The record for Resident 74 was reviewed on 9/4/25 at 2:13 p.m. Diagnoses included, but were not limited to, acute respiratory failure, diabetes, and dementia.The 8/15/25 Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, was dependent in activities of daily living (ADLs) and transfers, and was on hospice. A Physician's Order, dated 5/22/24, indicated to ensure the Foley catheter bag was covered and / or in a dignity bag.A Care Plan, dated 9/20/24, indicated the resident had a terminal condition, was receiving hospice services, and would suffer no loss of dignity. During an interview on 9/8/25 at 2:38 p.m., the Administrator and Nurse Consultant were informed of the findings and offered no further information.3.1-3(t)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident had the right to choose what time of day she received a shower for 1 of 1 resident reviewed for choices. (Resident 18)Finding includes:During an interview on 9/3/25 at 10:34 a.m., Resident 18 indicated she took a shower twice a week whenever the staff had time to give her one. The staff would have her take showers at nighttime. She had told them on multiple occasions that she preferred not to take a shower at night and preferred to take them in the morning. She did not like to go to bed with wet hair. Staff would tell her that was her scheduled time to take a shower but never asked her preference or when she wanted to shower. Record review for Resident 18 was completed on 9/8/25 at 1:22 p.m. Diagnoses included, but were not limited to, heart failure, hypertension, Parkinson's disease, and depression. The resident was admitted to the facility on [DATE]. The Annual Minimum Data Set (MDS) assessment, dated 6/3/25, indicated the resident was cognitively intact. The resident's preference was marked that it was very important to the resident to choose their bathing. The resident required partial moderate assistance with bathing. The Bathing Tasks were documented the resident preferred bathing on Wednesday and Saturday evenings. There was a lack of documentation that indicated the resident's preference for bathing was asked and not just assigned. During an interview on 9/9/25 at 9:23 a.m., the Assistant Director of Nursing (ADON) indicated she would talk with the residents and family when the residents were admitted about their bathing schedules. She would tell them what the schedule was for them and ask them if they were ok with that schedule. They did not have a process for asking residents after admission if their preferences had changed unless the resident or family expressed they preferred something different. The facility could not provide a policy related to choices and or preferences for bathing. 3.1-3(u)(1)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure there was indication for use and interventions were attempted prior to administering a PRN (as needed) antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 90)Finding includes:Record review for Resident 90 was completed on 9/4/25 at 8:49 a.m. Diagnoses included, but were not limited to, alcohol dependence with induced psychotic disorders with delusions, dementia, and hypertension. The resident was admitted to the facility on [DATE].A Care Plan, dated 8/29/25, indicated the resident had potential for adverse side effects related to medication use of an antipsychotic. An intervention included to administer the medications per order and to observe for side effects.A Physician's Order, dated 8/28/25, indicated to administer quetiapine fumarate (antipsychotic medication) 25 mg, give 1/2 a tablet every 24 hours as needed for agitation.A Fall Initial Occurrence Note, dated 8/28/25 at 9:45 p.m., indicated the resident had a fall in his room next to his bed. The resident was brought to the nurse's station and given a snack and milk per his request.An Orders Administration Note, dated 8/28/25 at 11:14 p.m., indicated the resident was administered the PRN antipsychotic medication.There was a lack of documentation as to why the resident was administered the medication almost an hour and a half after the fall incident or if any interventions were attempted prior to the administration of the PRN antipsychotic.An Orders Administration Note, dated 8/31/25 at 8:48 p.m., indicated the resident was administered a PRN antipsychotic medication.A Nurses Note, dated 8/31/25 at 8:50 p.m., indicated the resident was standing in his room naked and walking round. He was brought to the nurse's station in his Broda chair (padded positioning wheelchair) and given his PRN medication at that time.There was a lack of documentation to indicate if any interventions were attempted prior to administering the PRN antipsychotic.During an interview on 9/5/25 at 11:20 a.m., the Nurse Consultant (NC) indicated they could not provide any documentation that prior interventions were attempted before administering the resident the PRN antipsychotic medication.A policy, titled Psychotropic Medication - Gradual Dose Reduction, received as current from the NC indicated .The plan to alternatives to psychotropic medication and/or use of psychotropic shall be incorporated into the care plan with suitable goals and approaches.3.1-48(a)(4)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to successfully complete the Minimum Data Set (MDS) assessment in timely manner for 1 of 24 residents whose MDS assessments were reviewed. (Resident 6) Finding includes: Closed record review for Resident 6 was completed on 9/9/25 at 10:46 a.m. The resident was admitted to the facility on [DATE] and discharged on 5/14/25.A Nurses Note, dated 5/14/25 at 2:05 p.m., indicated the resident was discharged to another healthcare facility.There was a lack of documentation to indicate a discharge MDS assessment had been completed on the resident after his discharge from the facility. During an interview on 9/9/25 at 11:15 a.m., the MDS Coordinator indicated she had worked on the resident's discharge from the facility but had forgotten to complete the MDS discharge assessment.3.1-31(d)(1)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately completed related to an anticoagulant medication and insulin administered for 2 of 24 MDS assessments reviewed. (Residents 24 and 8) Findings include:1. Record review for Resident 24 was completed on 9/9/25 at 9:55 a.m. Diagnoses included, but were not limited to, anemia, hypertension, and diabetes mellitus. The Significant Change MDS assessment, dated 7/2/25, indicated the resident had received an anticoagulant medication during the assessment period. There was a lack of documentation of a Physician's Order for an anticoagulant medication or that the resident had received an anticoagulant medication during the assessment period. 2. Record review for Resident 8 was completed on 9/9/25 at 10:06 p.m. Diagnoses included, but were not limited to, heart failure, hypertension, and dementia. The Quarterly MDS assessment, dated 7/23/25, indicated the resident had received 7 days of insulin injections during the assessment period. There was a lack of documentation of a Physician's Order for insulin or that the resident had received insulin injections during the assessment period.During an interview on 9/9/25 at 11:15 a.m., the MDS Coordinator indicated there was a discrepancy with the MDS assessments and the residents had not received an anticoagulant or insulin during the assessment period. She marked them by mistake and would modify the assessments. The facility could not provide a policy related to MDS resident assessments. 3.1-31(i)

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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 assess and document a wound for 1 of 1 resident reviewed for non-pressure skin conditions. (Resident 32)Finding includes:During a random observation on 9/2/25 at 11:15 a.m., a dressing was observed on Resident 32's right leg stump. At that time, the resident indicated the surgical incision from her leg amputation had previously healed, but part had re-opened.The resident's record was reviewed on 9/4/25 at 12:11 p.m. Diagnoses included but were not limited to, bleeding stomach ulcer, stroke, and right leg amputation. The 8/14/25 Medicare-5 Day Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making, required maximum assistance with activities of daily living (ADLs) and moderate assistance with transfers. An 8/29/25 Physician's Office Visit Note indicated the orthopedic doctor saw the resident in his office. He consulted infectious disease as well as wound care for the resident's right stump infection. The record lacked any wound assessments since 8/21/25.During an interview on 9/4/25 at 8:24 a.m., the resident indicated she went to the wound clinic on the previous day and was going to go back for continued treatment for her right leg stump.During an interview on 9/4/25 at 8:34 a.m., LPN 2 indicated the resident had several small open areas along her previously healed right leg amputation incision.During an interview on 9/5/25 at 2:12 p.m., the Corporate Wound Nurse indicated the resident's surgical wound was healed on 8/21/25 and opened on 8/25/25. She indicated she would check with the facility wound nurse or wound clinic for wound assessments. No further documentation was provided. A policy, titled, Skin Condition Assessment and Monitoring-Pressure and Non-Pressure, received as current from the Corporate Nurse Consultant on 9/8/25 at 2:56 p.m., indicated, . A wound assessment will be initiated and documented in the resident chart when pressure and/or other non-pressure skin conditions are identified by licensed nurse.3.1-37

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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 resident's electronic smoking materials were locked up and fall precautions were in place for a resident with a history of falls for 2 of 11 residents reviewed for accidents. (Residents 58 and 82)Findings include:1. On 9/3/25 at 2:06 p.m., Resident 58 was observed lying in bed in his room. There were 2 electronic cigarette vapes observed on his bedside table. The resident's daughter was in the room and indicated his smoking vapes were supposed to be locked up. On 9/4/25 at 3:05 p.m., Resident 58 was observed propelling himself in his wheelchair out of his room. There were 2 electronic cigarette vapes observed on his bedside table. CNA 1 indicated the resident was going out to smoke and she was unsure if his smoking vapes were supposed to be locked up or not and she had not given the resident his smoking vapes. Record review for Resident 58 was completed on 9/4/25 at 2:20 p.m. Diagnoses included, but were not limited to, hypertension, diabetes mellitus, dementia, chronic obstructive pulmonary disease, and legal blindness. The Significant Change Minimum Data Set (MDS) assessment, dated 8/20/25, indicated the resident was moderately cognitively impaired. The resident required a partial moderate assistance with transfers. A Care Plan, dated 11/17/23, indicated the resident had been deemed an unsafe smoker and could no longer smoke cigarettes. The resident had refused smoking cessation and had agreed to an electronic cigarette. An intervention included the resident's smoking materials were to be in a secure location. A Smoking Safety Risk Assessment, dated 7/31/25, indicated the resident used an electronic smoking device. All smoking materials would be kept locked in facility designated area. During an interview on 9/5/25 at 11:51 a.m., the Social Services Director indicated the resident was a safe smoker for electronic cigarette vaping. He was not supposed to keep the vapes out in the open on his bedside table. A policy titled, Smoking Safety and received as current from the facility on 9/4/25, indicated, .A Smoking Safety Assessment will be completed to ensure that the resident is capable of safe storage, charging and use of the electronic cigarette or vaping device. 2. On 9/3/25 at 9:25 a.m., Resident 82 was observed lying in bed. He had sutures to his forehead and a neck brace in place. He indicated he had fallen recently and hit his head. He had gone to the hospital and now had to wear a neck brace. His wheelchair was next to his bed and there was no Dycem (non-slip mat) observed on the seat. There were no non-skid strips on the floor in his bathroom. On 9/4/25 at 10:20 a.m., Resident 82 was observed lying in bed with his eyes closed. His wheelchair was next to his bed and there was no Dycem observed on the seat. There were no non-skid strips on the floor in his bathroom. Record review for Resident 82 was completed on 9/4/25 at 9:13 a.m. Diagnoses included, but were not limited to, displaced fracture of the first cervical vertebra, type 2 diabetes mellitus, and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hypertension. The Quarterly MDS assessment, dated 6/4/25, indicated the resident was moderately cognitively impaired and required a partial/moderate assist with bed mobility and transfers. A Care Plan, updated 6/18/25, indicated the resident was at risk for falls. The interventions included, Dycem to the wheelchair seat above the cushion and non-skid strips in front of the toilet. During an interview on 9/8/25 at 11:47 p.m., the Director of Nursing was made aware of the Dycem and non-skid strips not in place. No further information was provided. A current facility policy, titled Fall Prevention Program, indicated, .Safety interventions will be implemented for each resident identified at risk.Nursing personnel will be informed of residents who are at risk of falling. The fall risk interventions will be identified on the care plan. 3.1-45(a)

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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 record review and interview, the facility failed to ensure food consumption logs were complete for residents with a history of weight loss for 1 of 3 residents reviewed for nutrition. (Resident 20)Finding includes:The record for Resident 20 was reviewed on 9/3/25 at 3:49 p.m. Diagnoses included, but were not limited to, heart disease, pressure ulcer of buttock, and dementia.The 8/18/25 admission Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, required maximal assistance with ADLs and transfers, and had a weight loss of 5% or more in the last month or 10% or more in last 6 months. The resident's record lacked documentation of 3 meal intakes per day on 8/13/25, 8/14/25, 8/16/25, 8/17/25, 8/18/25, 8/19/25, 8/20/25, 8/23/25, 8/25/25, 8/28/25, 8/29/25, 9/1/25, and 9/2/25.A care plan, revised 8/13/25, indicated the resident was at risk for fluctuations in weight. Interventions included monitoring and recording the resident's intake each shift.During an interview on 9/4/25 at 11:50 a.m., the MDS Coordinator indicated the resident had a weight loss of 8.6 pounds in the past 3 months (4%) and 40 pounds (16.2%) in the past 7 months, based on the Dietician's notes from the facility from where the resident transferred. During an interview on 9/8/25 at 2:38 p.m., the Nurse Consultant indicated the resident's meal consumptions should be documented three times a day, once each shift. A policy titled, Food Intake, received as current from the Corporate Nurse Consultant on 9/8/25 at 2:56 p.m. indicated, . Food intake will be recorded by assigned staff. All personnel recording intakes will receive instructions on method used, recording intake on community specific form or electronic monitoring system.3.1-46(a)(1)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 1 of 11 residents observed during medication pass. Two errors were observed during 26 opportunities for errors during medication administration. This resulted in a medication error rate of 7.69%. (Resident 17) Finding includes:On 9/5/25 at 3:11 p.m., RN 1 was observed preparing Resident 17's medications to be administered. The nurse popped out 1 Flomax 0.4 mg (milligrams) capsule (urinary medication) and 1 senna 8.6 mg (stimulant laxative) pill into a cup. She then proceeded to place the medications into a clear plastic bag and crushed the medications. She poured the crushed medications into a cup and put a spoonful of pudding on top of the medications and stirred. The capsule was not crushed and was flattened out but still intact. The nurse indicated she was finished and ready to administer the resident's medications. The nurse locked her medication cart and proceeded to go into the resident's room. The nurse was then asked to stop and not to administer the medication. The nurse was asked if she always crushed capsule medications. The nurse indicated yes because she did not want to open the capsule and get it all over. She was unaware capsules could not be crushed.The resident's senna 8.6 mg medication card and current Physician's Order indicated to give 2 pills every evening.The nurse indicated she had only popped out 1 senna pill to administer to the resident and had not realized the order was for 2 pills.During an interview after the observation, the Director of Nursing (DON) indicated the nurse should have opened up the Flomax capsule instead of crushing it and administered two senna pills instead of one.A policy titled, Medication Administration General Guidelines and received as current from the DON on 9/9/25, indicated, .6. Five Rights - Right resident, right drug, right dose, right route and right time, are applied for each medication being administered.8. Tablet Crushing/Capule Opening: Crushing tablets may require a physician's order, per facility policy. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed.3.1-48(c)(1)

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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 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 record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to duplicate medications on the Medication Administration Record (MAR) for 1 of 5 residents reviewed for unnecessary medications. (Resident 10)Findings include:The record for Resident 10 was reviewed on 9/8/25 at 10:23 a.m. Diagnoses included, but were not limited to, dementia and diabetes.The 8/5/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had moderate cognitive impairment and required supervision or touching assistance with activities of daily living (ADLs) and transfers.The September 2025 MAR indicated, . Carboxymethylcellulose Sodium Ophthalmic Solution 0.5% [a lubricating eye drop] . Instill 1 drop in both eyes one time a day. and .Refresh Tears Solution (Carboxymethylcellulose Sodium) Instill 1 drop in both eyes one time a day. Both entries were signed out as given each morning. During an interview on 9/8/25 at 11:03 a.m., LPN 1 indicated the resident received one drop to each eye every morning, and that the duplicate order was entered in error. She indicated she did not notice it when she administered and signed out the medications that morning, and that she would delete one of the entries.During an interview on 9/8/25 at 11:47 a.m., the Director of Nursing (DON) was informed of the finding. No additional information was received.3.1-50(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Demotte	10352 N 600 E County Line Rd Demotte, IN 46310

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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 - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure infection control practices were implemented related to a dirty bedside table used for wound care supplies and lack of hand hygiene with glove changes during wound care for 1 of 1 resident reviewed for pressure ulcers. (Resident 20)Finding includes:Wound care for Resident 20 was observed on 9/4/25 at 7:10 a.m. After removing the old dressing, the Wound Nurse took gauze that was placed directly on a bedside table, soaked it in Dakin's solution (a wound cleanser), and used it to cleanse the open wound on the resident's buttock. There was no barrier, and the table was visibly dirty. The Wound Care Physician assessed and measured the wound, removed his gloves, and put on gloves he got from his pocket. He debrided the wound, again removed his gloves and put on gloves from his pocket, and cleansed inside the open wound with gauze from the table. He did not perform hand hygiene after removing his gloves. During an interview on 9/4/25 at 7:40 a.m., the Wound Nurse indicated she told someone to clean the bedside table earlier, but she was not sure what happened. During an interview on 9/4/25 at 7:50 a.m., the Wound Care Physician was informed of the findings and offered no further information.A policy titled, Dressing Change (Clean / Non-Sterile), received as current from the Administrator on 9/4/25 at 1:25 p.m., indicated, . Prepare a clean, dry work area at bedside. Bring supplies into the resident's room. Individual resident supplies may be placed on the over bed table after it has been disinfected and / or a protective barrier placed on the table.A policy titled, Hand Hygiene / Handwashing, received as current from the Administrator on 9/4/25 at 1:25 p.m., indicated, . When to Perform Hand Hygiene . After glove removal.3.1-18(a)