STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155655	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peabody Retirement Community	400 W Seventh St North Manchester, IN 46962

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42685 Based on observation, interview, and record review, the facility failed to follow physician orders regarding blood glucose monitoring, insulin administration, and elastic wraps (for swelling) for 2 of 26 residents reviewed for following physician orders. (Residents 90 and 82) Findings include: 1. Resident 90's clinical record was reviewed on 4/26/24 at 3:34 p.m. Diagnoses included type 2 diabetes mellitus and hypothyroidism. A current physician order, dated 3/28/24, indicated metformin (diabetes medication) 1000 milligrams (mg), give 1 tablet by mouth twice a day. A physician order, dated 6/18/23, included check blood sugar two times daily. The order was discontinued on 4/22/24. A physician order, dated 7/1/23, included Novolog Flexpen (insulin for diabetes) 100 units/milliliters, inject subcutaneously every morning and at bedtime per sliding scale: if blood glucose is 150 - 200 = 2 units, 201 - 250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351 - 400 = 10 units. The order was discontinued on 4/22/24. A quarterly Minimum Data Set (MDS) assessment, dated 3/1/24, indicated the resident was cognitively intact and received insulin seven out of seven days during the assessment period. A Nurse's Note, dated 3/1/24 at 2:33 p.m., indicated new orders were received to monitor and chart if the resident's blood glucose was less than 100 mg/dL at night and to chart if the night insulin was held. A current care plan, dated 3/8/24, indicated the resident had diabetes mellitus. Interventions included to administer diabetes medication as ordered by the physician (3/8/24), and obtain fasting blood sugar as ordered by the physician (3/8/24). Review of the Medication Administration Record (MAR) for March and April 2024 indicated the following information: The resident's blood sugar was not obtained as ordered on 3/10/24 in the evening. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/15/24, the resident's blood sugar in the evening was 211 mg/dL. Novolog was not administered according to the physician-ordered sliding scale. The resident's blood sugar was not obtained as ordered in the evenings on 4/7/24 and 4/15/24. The clinical record lacked documentation indicating the resident refused the blood glucose monitoring, medication, or was out of the facility. Review of the Leave of Absence Logs from 1/1/24 to 4/30/24 indicated the resident was not on leave of absence during the above mentioned dates and times. During an interview on 4/30/24 at 10:13 a.m., QMA 18 indicated blood glucose testing was completed by QMAs, charted in the clinical record, and reported to the nurse on duty for administration of the insulin. Physician orders must be completed as ordered. During an interview on 4/30/24 at 11:51 a.m., LPN 3 reviewed the resident's Medication Administration record and indicated the resident's clinical record lacked blood glucose monitoring according to the physician orders on the above mentioned dates in March and April. It should have been documented in the resident's clinical record on the MAR or nurse's notes if the resident refused or was out of the building. On 3/15/24, the resident's evening blood sugar was 211 mg/dL, and the resident should have received 4 units of Novolog, but did not. If the blood sugars were obtained or insulin was administered, it could not be verified since it was not charted. During an interview on 5/1/24 at 8:58 a.m., the DON indicated the resident's physician orders for blood glucose monitoring and sliding scale insulin should have been followed. During an interview on 5/1/24 at 9:55 a.m., the DON indicated staff would not have a way to know how much sliding scale insulin to administer when blood glucose testing was not obtained. 48146 2. During an observation, on 4/24/24 at 12:20 p.m., Resident 82 was lying in bed without pants. His bilateral lower legs had a dark discoloration from his ankles to mid-calf. During an observation and interview, on 4/25/24 at 9:30 a.m., Resident 82 was lying in bed without pants, His bilateral lower legs had a purplish discoloration from his ankles to mid calf. Resident 82 indicated he was concerned about his legs since he had poor circulation and the daily wraps for this legs were not being completed by the staff. During an observation, on 4/25/24 at 11:24 a.m., Resident 82 was seated in a wheelchair, playing cards with another resident. Resident 82's bilateral lower legs had a purplish discoloration from his ankles to mid calf. His legs were not wrapped. During an observation and interview, on 4/26/24 at 10:05 a.m., Resident 82 was lying in bed. His bilateral lower legs had a purplish discoloration from his ankles to mid calf and were not wrapped. Resident 82 indicated he spoke with the night nurse about his leg wraps and was advised the order was for the day shift to complete. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview, on 4/29/24 at 9:51 a.m., Resident 82 was lying in bed. His bilateral lower legs had a purplish discoloration from his ankles to mid calf. His legs were not wrapped. He indicated his legs hurt and when his legs were wrapped, the compression from the wraps helped. He was able to get his legs wrapped on Sunday, but not on Saturday. He was supposed to have therapy today, but planned to ask if the time could be adjusted since his legs hurt this morning. During an observation and interview, on 4/29/24 at 2:38 p.m., Resident 82 was lying in bed with an elastic bandage wrapped around his bilateral lower legs from his ankle to his calf. Resident 82 indicated the mild compression was helpful in pain relief. During an observation and interview, on 4/30/24 at 9:55 a.m., Resident 82 was lying in bed. His bilateral lower legs had a purplish discoloration from his ankles to mid calf. His legs were not wrapped. Resident 82 indicated he his legs hurt today and he was waiting on the staff to come apply his leg wraps. During an observation on 4/30/24 at 10:58 a.m., Resident 82 was lying in bed without pants on. His bilateral lower legs had a purplish discoloration from his ankles to mid calf and were not wrapped. Resident 82's clinical record was reviewed on 4/26/24 at 1:49 p.m. Diagnoses included morbid (severe) obesity due to excess calories, diabetes mellitus, type 2, unspecified gout, and chronic peripheral venous insufficiency. Current physicians orders, dated 7/4/23, indicated to apply Ace Wraps (elastic bandages) to both legs after washing and applying petroleum jelly to treat every morning for edema, and remove the wraps in the evening. A current care plan, initiated 10/16/20, indicated Resident 82 was at risk for impaired skin integrity related to venous insufficiency, diabetes mellitus, obesity, and history of pressure areas. The interventions included: Evaluate skin for areas of blanching or redness (10/16/20), evaluate skin for redness or excoriation (10/16/20), provide skin care per facility guidelines and PRN as needed (10/16/20). A review of the electronic treatment administration record, for the dates of 4/24/24 through 4/30/24, indicated Resident 82's legs were wrapped as ordered on the following days: 4/24/24, 4/25/24, 4/27/24, 4/28/24, and 4/29/24. The record lacked documentation for 4/26/24. During an interview, on 4/30/24 at 2:11 p.m., LPN 12 indicated the resident liked to do things on his own time frame. He would sometimes refuse care and refusals were documented in the electronic medical record. During an interview, on 4/30/24 at 2:19 p.m., QMA 10 indicated Resident 82 had good days and bad days and required some encouragement to allow staff to complete care. If the resident refused medications, the QMA would notify the registered nurse and document the refusal in the electronic medical record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 4/30/24 at 2:44 p.m., Unit Manager 11 indicated Resident 82 refused treatments based on his mood or who the staff member was providing the care. Refusals should be documented in the electronic medical record and treatments should be completed prior to checking the tasks off in the treatment record. A current facility policy, revised 12/31/23, titled Physician Orders, provided by the DON, on 4/30/24 at 9:56 a.m., indicated the following: . Implementation of Orders. The facility is responsible for the carrying out of physician orders as written. The order may be carried out by the staff member who is legally permitted to carry out such order . 3.1-37(a)

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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** 45122 Based on observation, record review, and interview, the facility failed to provide monitoring of a pressure injury (Resident 5) and failed to develop and implement interventions to promote the healing of pressure injuries (Residents 5 and 120). for 2 of 3 residents reviewed for pressure injuries. Findings include: 1. During an observation, on 4/26/24 at 10:00 a.m., Resident 5 sat in her wheelchair in her room and wore non-skid shoes on both feet. During an observation, on 4/26/24 at 2:19 p.m., the resident sat in her wheelchair in the activity area and wore non-skid shoes on both feet. Resident 5's clinical record was reviewed on 4/25/24 at 4:24 p.m. Diagnoses included type 2 diabetes mellitus without complications, hypertensive heart disease with heart failure, chronic diastolic (congestive) heart failure, chronic kidney disease stage 3, pressure of left heel unstageable, and need for assistance with personal care. Current physician's orders included, but were not limited to the following: inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness every night shift (initiated 4/21/23) and treatment: left heel: cleanse with normal saline (NS) and gauze, pat dry, paint with povidone iodine. Notify NP of any adverse reactions every day shift for wound care. No shoe to left foot. (initiated 1/31/24). A hospital wound assessment for 9/20/23 at 10:56 a.m. indicated the resident had a type 3 skin tear (entire wound bed exposed) to the left posterior heel with total flap loss. The wound bed was moist with slough (dead cells generally yellow/white) present. The wound measurements were 1.8 cm (centimeters) long by 1 cm wide and was dressed with a bordered foam dressing. A hospital wound assessment for 9/21/23 at 3:23 p.m. indicated the resident had a type 3 skin tear to the left posterior heel with total flap loss. The wound bed was moist with slough present and was dressed with a bordered foam dressing. A facility Nurses Note, dated 9/21/23 at 10:59 p.m., indicated the resident arrived from the hospital at 7:20 p. m. An Admission/Readmission/Quarterly Nursing Evaluation, dated 9/21/23 at 11:36 p.m., indicated Resident 5 returned from the hospital. An unstageable left heel pressure area was listed under the pressure injury assessment section and lacked measurements. The Notable changes to skin integrity documented in complete sentences section included pressure area to left heel and lacked measurements for the area. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A significant change Minimum Data Set (MDS) assessment, completed on 9/28/23, indicated Resident 5 was severely cognitively impaired, was dependent on staff for lower body dressing and putting on/taking off footwear, and required substantial/maximal assistance to roll left and right in bed. She was at risk for developing a pressure injury and did not have a pressure injury. The clinical record lacked wound descriptions, wound measurements, and treatment orders for the wound identified upon readmission to the facility on [DATE], from 9/22/23 through 10/18/23. A current care plan indicated Resident 5 had a pressure wound (unstageable) to the left heel (initiated on 10/9/23 and revised on 1/23/24). The interventions included measure area weekly (10/9/23), administer treatment as ordered (10/9/23), and monitor for change in condition and infection until healed. Notify MD/NP as needed (10/9/23). A Nurses Note, dated 10/19/23 at 9:31 a.m., indicated the staff had reported to the nurse the resident had an area to the left heel. The area was purple/red in color, tender to touch, and not open. The measurements were documented as 2.5 x 2 x 5 x < [less than] 0.2 cm (centimeters). A Nurses Note, dated 10/19/23 at 5:28 p.m., indicated the area to the left heel was a deep tissue injury (DTI) (purple or maroon area of discolored intact skin due to damage of underlying soft tissue) and measured 2.5 cm by 2.5 cm by less than 0.2 cm. The area was tender to touch and had no drainage. The resident's family member indicated the area to the heel was present in the hospital in September. A Nurses Note, dated 10/23/23 at 1:11 a.m., indicated the resident had a pressure injury. The area was reddish-brown in color and soft to touch with firm edges. A Provider Note, dated 10/23/23 at 11:37 p.m., by the Wound NP, indicated the resident had an unstageable left heel pressure injury that measured 2.0 cm by 3.0 cm, with a necrotic (dark, dead tissue), firmly adherent wound bed. A Provider Note, dated 11/14/23 at 12:52 p.m., by the Wound NP for date of service on 11/6/23, indicated the pressure injury to the left heel was a stage 3 (full thickness loss of skin) pressure injury. The measurements were 1.5 cm long by 1.7 cm wide by 0.1 cm deep. Orders were written to apply calcium alginate and silicone bordered foam every 3 days and as needed, use an offloading boot except to transfer, and no left shoe to be worn. A Provider Note, dated 12/19/23 at 11:52 a.m., by the Wound NP, indicated the left heel pressure injury was a stage 3 and measured 0.7 cm long by 0.5 cm wide by 0.1 cm. The wound bed was 100 percent slough with no drainage. A Provider Note, dated 1/9/24 at 11:51 a.m., by the Wound NP, indicated the left heel pressure injury was unstageable and measured 1.5 cm long by 2.0 cm wide by 0.1 cm deep and was 100 percent scabbed. A Wound Assessment, dated 2/13/24 at 3:45 p.m., indicated the left heel pressure injury measured 1.0 cm long by 1.5 cm wide with no depth. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly MDS assessment, completed on 2/26/24, indicated Resident 5 was severely cognitively impaired, was dependent on staff for lower body dressing, putting on/taking off footwear, and rolling from right to left in bed. She was at risk for developing a pressure injury and had an unstageable wound due to coverage of slough and/or eschar pressure injury that was present upon admission or reentry. A Wound Assessment, dated 4/9/24 at 9:39 a.m., indicated the left heel pressure injury measured 1 cm long by 1.5 cm wide. The wound bed was 100 percent callus. The area under the callus was soft. A Nurses Note, dated 4/9/24 at 2:45 p.m., indicated the resident's left heel callus was mechanically debrided without pain or injury. A Wound Assessment, dated 4/23/24 at 10:29 a.m., indicated the resident's left heel pressure injury measured 0.3 cm long by 0.5 cm wide with no depth. The wound bed was 100 percent callus. During a wound treatment observation, on 4/26/24 at 3:34 p.m., LPN 12 cleansed the resident's left heel with normal saline. The pressure area was a pea-sized, brownish-white callus area on the posterior left heel. Povidone iodine was applied to the left heel and permitted to dry. After the feet were washed, rinsed, and dried socks and shoes were applied. During an observation, on 4/29/24 at 9:48 a.m., the resident sat in a wheelchair in the common area near the activity area and wore non-skid shoes on both feet. During an observation, on 4/30/24 at 10:06 a.m., the resident sat in a wheelchair in the common area and wore non-skid shoes on both feet. During an interview, on 4/30/24 at 10:26 a.m., CNA 9 indicated Resident 5 wore offloading boots while in bed and shoes during the day. The CNA utilized the Kardex on the computer to know what interventions were needed for the residents. During an interview, on 4/30/24 at 11:22 a.m., QMA 10 indicated the area to Resident 5's heel started hurting and had opened, but the QMA was uncertain when it occurred. The resident wore her pressure relieving boots in bed and her shoes when up. A Kardex report for Resident 5, provided by Unit Manager 11 on 4/30/24 at 11:26 a.m., indicated Resident 5's care interventions included a pressure reducing mattress. The Kardex lacked directions for no shoe to the left foot. During an interview, on 4/30/24 at 11:27 a.m., Unit Manager 11 indicated pressure wounds were measured one time a week by the wound team. During an interview, on 5/1/24 at 10:28 a.m., the DON indicated Resident 5 came to the facility after her hospital stay with a pressure injury. The hospital had indicated the resident had a stage 3 skin tear on her left heel and was identified by the hospital on 9/15/24. The hospital said it was healed. She did not believe it was a healed skin tear. She had contacted the Wound NP and discussed the area to the resident's left heel with her. The Wound NP had told her to monitor it. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 5/1/24 at 10:34 a.m., the DON indicated the resident did not have any ordered treatments from the hospital upon admission to the facility. The facility believed it started in the hospital. If it was a pressure injury in the hospital, then it was not going to heal, so it was captured on the admission assessment. It was red, but it was closed. It looked like a healed wound. On 10/19/23, the area started to develop dark tissue around it. The damage was already there and began to surface. It took a couple of years for the tissue to be completely healed with a deep tissue injury. The weekly skin assessments would not have documented anything about the area to the left heel because they only addressed new things or changes. During an interview, on 5/1/24 at 11:06 a.m., the Wound NP indicated she had spoken to the facility about the resident's left heel area upon return from the hospital. The NP did not believe the area was a skin tear, but was a pressure related injury. The NP had told the facility they needed to watch it closely, as it may have looked healed, but was highly likely to open. In October of 2023, another wound nurse began looking at it every week. The Wound NP was uncertain about the no left shoe order, as another wound nurse on the team was currently providing care for the resident. During an interview, on 5/1/24 at 11:27 a.m., the DON indicated Resident 5's skin concern could have been a healed skin tear and was red tissue, which could have been either. The area had discoloration. They were monitoring red tissue. The DON was unaware that the current treatment order indicated no left shoe. The nurse should have been monitoring for this when the order was signed off. During an interview, on 5/1/24 at 2:44 p.m., RN 14 indicated she had completed the admission assessment on 9/21/24 for the resident's return to the facility. The nurse was unable to recall details about the resident's skin condition. Whatever she documented is what she saw. If the area was not open, she would not have not gotten measurements. An article titled, Evolution of Deep Tissue Pressure Injury, dated 1/8/21, retrieved on 5/2/24 from the National Pressure Injury Advisory Panel (NPIAP) website at https://npiap.com/news/546664/Evolution-of-Deep-Tissue-Pressure-Injury.htm, indicated the following: .The process leading to deep tissue injury precedes the visible signs of purple or maroon skin by about 48 hours. Then about 24 hours later, the epidermis lifts and reveals a dark wound bed. This phase of deep tissue injury evolution is often confused with skin tears. Within another week, the wound bed is often necrotic . 48146 2. During an observation, on 4/25/24 at 11:06 a.m., Resident 120 was seated in his recliner with his legs elevated. He had a dressing to his left heel and wore non-slip socks. During an observation, on 4/26/24 at 9:56 a.m., Resident 120 was fully dressed. He was seated in his recliner with non slip socks to bilateral feet. During an observation, on 4/29/24 at 10:08 a.m., Resident 120 was seated in his recliner with non slip socks on his bilateral feet. A pair of pressure relief boots were on the top of the dresser. Two handwritten signs were taped to the dresser doors in his room and indicated the following: Wear pressure relief boots to bed. Left boot at all times. During a catheter care observation, on 4/29/24 at 2:27 p.m., QMA 23 and CNA 24 indicated Resident 120 did not have his offloading boot on his left foot. His left foot dressing was dated 4/28/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, on 4/30/24 at 12:08 p.m., Resident 120 was seated in the dining room. He wore non-slip socks to his bilateral feet. He was not wearing an offloading boot to his left foot. Resident 120's clinical record was reviewed on 4/26/24 at 9:28 a.m. Diagnosis included adult failure to thrive, unspecified protein-calorie malnutrition, and pressure ulcer of unspecified heel. A current physician's order, dated 4/2/24, indicated to cleanse the left heel with normal saline and gauze, pat dry, apply skin prep to periwound, use Medihoney (a wound gel to promote healing) and foam dressing daily and as needed, every night for wound care. A current physician's order, dated 1/30/24, indicated off loading boot to left foot at all times, except for showers and morning or night care. A review of the April 2024 treatment administration record, on 4/30/24 at 2:29 p.m., indicated the treatment as completed and the off loading boot was in place daily. No refusals were documented. A care plan, initiated on 3/3/23, indicated the resident had an unstageable to his left inner heel present on 3/3/23. Resident 120 had protein calorie malnutrition, history of wounds, slow healing, adult failure to thrive, required assistance with bed mobility, and had cardiovascular issues. Interventions included administer treatment as order, heel boots while in bed, and offloading boot to left foot. A wound note, dated 3/26/24, indicated the left heel was originally categorized at deep tissue injury and had a history of stage 3 pressure ulcer. The wound measurements were a width of 0.3 cm by length of 0.3 cm and was scabbed over. A wound note, dated 4/2/24, indicated the left heel was originally categorized at deep tissue injury and had a history of stage 3 pressure ulcer. The wound measurements were a width 0.3 cm by length of 0.3 cm and depth of 0.2 cm. A wound note, dated 4/23/24, indicated the left heel wound was originally categorized at deep tissue injury and Resident 120 had a history of stage 3 pressure ulcer (Full-thickness skin loss). Measurements were width of 0.3 centimeters (cm) by length of 0.3 cm and depth of 0.1 cm. The wound was currently unchanged. The previous wound notes on 4/16/24 and 4/9/24 indicated the same information. A progress note, dated 4/26/27 at 3:27 a.m., indicated the resident refused to wear the left heel boot. A provider note, dated 4/16/24 at 10:50 a.m., indicated the resident had multiple underlying medical co-morbidities and need for assistance with activities of daily living. He had history of a left heel pressure sore for several months. Wound care continued to follow for the left heel pressure ulcer. During a wound observation and interview, on 4/29/24 at 4:07 p.m., Unit Manager 11 indicated Resident 120's wound used to cover the entire heel. The resident did not like to wear the left heel boot and would kick it off. The activity staff had documented this in the electronic medical record. The Unit Manager could not provide documentation to confirm the resident kicked off or removed the left heel boot. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 4/30/24 at 2:44 p.m., Unit Manager 11 indicated the check off done by the activities and certified nursing aide (CNA) staff did not have an area to document when the resident would kick off the boot after it was applied. The staff had to amend the charting or add additional documentation later. A current facility policy, revised 4/18, titled Pressure Ulcers/Skin Breakdown- Clinical Protocol, provided by the DON on 4/30/24 at 4:22 p.m., indicated the following: .Treatment/Management. 1. The physician will order pertinent treatments, including pressure reduction surfaces or devices 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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48384 Based on observation, interview, and record review, the facility failed to make nursing staffing data readily available in a prominent, easily accessible location for residents and visitors. Findings include: On 4/25/24, at 2:15 p.m., a binder labeled Nursing Daily Schedules was located at the reception desk on a raised ledge. The binder contained schedules for 4/25/24, but lacked hours worked and specific nursing roles, such as RN and LPN. At the same time, Receptionist 19 indicated she did not know where to find the nurse staffing posting. During an observation of the Evergreen Park unit, on 4/25/24 at 2:18 p.m., no staffing information was posted. During an observation of the [NAME] Way unit, on 4/25/24 at 2:21 p.m., no staffing information was posted. During an observation of the Magnolia Lane unit, on 4/25/24 at 2:26 p.m., no staffing information was posted. During an observation on 4/29/24 at 9:15 a.m., no staffing information was posted. During an observation of the Health Care [NAME] unit, on 4/25/24 at 2:33 p.m., no staffing information was posted. During an observation on 4/29/24 at 9:02 a.m., no staffing information was posted. On 4/26/24 at 11:40 a.m., a daily nursing schedule binder, at the reception desk, contained a schedule dated 4/26/24 but lacked specific hours and nursing roles, such as RN and LPN. During an observation on 4/29/24, at 8:25 a.m., no staffing information was posted in the entryway, the reception area, or the hallways. On the same day, at 8:40 a.m., a binder labeled Nursing Daily Schedules, was on the ledge at the reception desk. The binder contained a schedule for 4/29/24 but did not include a breakdown of nursing roles and hours. On 4/29/24 at 8:45 a.m., no staffing or hours were posted on the Tulip Place unit. On 4/29/24 at 8:49 a.m., no staffing or hours were posted on the TCU unit. During an interview, on 4/29/24 at 4:35 p.m., the DON indicated she was unable to provide the nurse staffing information. She thought the information was in a binder at the reception desk, but would need to check with another staff member. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview, on 4/29/24 at 4:42 p.m., the Administrator indicated she thought the staffing breakdown was posted at the reception desk. She looked around the desk and could not locate the posting. On 4/29/24 at 4:44 p.m., the DON located the posting in an area behind the reception desk. She indicated it should have been readily available and posted for the public. The posting was sitting parallel to a wall, on a counter approximately eight feet behind the reception desk. To read it, someone would have to go to the area behind the reception desk. The information could not be seen because the print side was not facing forward, and the font was not readable from the reception desk. On 4/30/24, at 9:50 a.m. the DON provided a current, undated, policy titled Daily Nursing Staffing Data Posting. The document included the following information: .Policy: It is the policy of [NAME] Retirement Community that we provide adequate staffing to meet our resident needs and maintain compliance with the Indiana State Department of Health guidelines for posting the daily nurse staffing data. Procedure: 1. The facility will ensure that the daily nurse staffing data is posted: a) In a visible area for view of the public, visitors, residents, staff, and all others. b) Will contain the number of hours worked on each shift by the type of staff, i.e., RN, LPN, QMA, and CNA

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09676 Based on observation, interview, and record review, the facility failed to develop and implement a system of individualized behavior monitoring and management that provided information for assessment to develop individualized interventions to prevent recurrence of behavior expressions for 1 of 4 residents reviewed for dementia services (Resident 85). Findings include: During an observation on 4/24/24 at 12:27 p.m., Resident 85 was seated in a wheelchair in the lounge area. He was calm. During an observation on 4/25/24 from 9:51 a.m. to 10:00 a.m., the resident was seated a chair in the lounge attending a remembering activity. He was calm. During an observation on 4/30/24 at 11:04 a.m., the resident was seated in a wheelchair in the lounge. His eyes were closed and his chin was to his chest. During an observation on 4/30/24 at 2:50 p.m., the resident was seated in a wheelchair in the lounge. His eyes were closed and his chin was to his chest. Resident 85's clinical record was reviewed on 4/30/24 at 9:55 a.m. Current diagnoses included unspecified dementia without behavioral disturbances, Parkinson's disease, delusional disorder, and major depressive disorder recurrent. The resident had a current (originated 2/16/23) physician's order to reside on a locked dementia care unit. The resident also had a current (originated 2/1/21) order for Nuplazid 34 mg- take 1 tablet daily (an atypical anti-psychotic medication used to treat Parkinson's disease with related delusions or hallucinations.) A 2/27/24 late entry Providers Note indicated the behavioral management committee had meet to discuss a gradual dose reduction of Nuplazid. The resident was deemed not to be a candidate for dose reduction because the staff reported the resident continues to have episodes of delusions and hallucination. Review of Resident 85's progress notes indicated no documented Behavioral Notes since 1/11/24, when he resisted personal care. There were no documented Social Services Notes since 12/8/2020. There were no documented Psychosocial Notes since 1/21/22. The progress notes for 4/29/24 through 2/1/24 lacked notes regarding displayed behaviors, the location of the event, what activity or action proceeded the behavioral event, and which staff were present when the behavioral event occurred. A 3/18/24, quarterly, Minimum Data Set (MDS) assessment indicated the resident was moderately cognitively impaired, and had displayed no delusions or hallucinations during the assessment period. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 85 had a current care plan problem/need, which originated 9/8/20 and was revised 11/7/22, regarding the use of an antipsychotic medication in relationship to delusions and hallucinations related to Parkinson's disease. An approach to this problem was monitoring/record occurrence of target behaviors symptoms (pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc.) and document per facility protocol. The resident had a current care plan problem/need, which originated 12/15/20, regarding making inappropriate comments towards staff. An approach to this problem/need was to monitor behavior episodes and attempt to determine underlying causes. Consider location, time of day, persons involved, and situations. Document behaviors and potential causes. The Behavior Monitoring and Intervention Report for February 2024, prior to the decision to consider Nuplazid based on behaviors, indicated the following: A 2/2/24 at 11:19 p.m. entry contained check marks in the columns of grabbing others, hitting others, pushing others, physically aggressive towards others, accusing of others, express frustration/anger at others, threatening others, agitated, anxious/restless, delusions, hallucinations, insomnia/not sleeping, and refused care. Additional checkmarks indicated he was redirected, removed from situation, and provided a calm environment, reapproach, and one to one support with worsened behaviors. The clinical record lacked documentation regarding where the event occurred, what event proceeded or precipitated the behavior, what staff were present, if any other residents were present, what aggression was displayed, who he grabbed, hit and or pushed, environmental considerations (such as temperature, noise, or lighting), a narrative description of what behavioral symptom the resident displayed, what resident specific interventions were attempted, what type of care was refused, and/or how long the behavior was exhibited. A 2/3/24 at 11:13 p.m. entry contained check marks in the columns pushing others, physically aggressive towards others, expressed frustration/anger at others, agitated, anxious/restless, delusions, hallucinations, and refusing care. Additional checkmarks indicated he was redirected, removed from situation, and provided a calm environment with unchanged behaviors. The clinical record lacked documentation regarding where the event occurred, what event proceeded or precipitated the behavior, what staff were present, if any other residents were present, what aggression was displayed, who he pushed, environmental considerations (such as temperature, noise, or lighting), a narrative description of what behavioral symptom the resident displayed, what resident specific interventions were attempted, what type of care was refused, and/or how long the behavior was exhibited. A 2/8/24 at 11:41 p.m. entry contained a check mark in the column for [undefined] delusions. Additional checkmarks indicated he provided a calm environment, offered meaningful activities, and reapproached with unchanged behaviors. The clinical record lacked documentation where the event occurred, what event proceeded or precipitated the behavior, what staff were present, if any other residents were present, environmental considerations (such as temperature, noise, or lighting), a narrative description of what behavioral symptom the resident displayed, what resident specific interventions were attempted, and/or how long the behavior was exhibited. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 2/19/24 at 2:02 p.m. entry contained check marks in the columns for agitated and [undefined] delusions. Additional checkmarks indicated he was redirected and removed from the situation with improved behaviors. The clinical record lacked documentation of where the event occurred, what event proceeded or precipitated the behavior, what staff were present, if any other residents were present, environmental considerations (such as temperature, noise, or lighting), a narrative description of what behavioral symptom the resident displayed, what resident specific interventions were attempted, and/or how long the behavior was exhibited. A 2/22/24 at 12:01 a.m. entry contained check marks in the columns of [undefined] delusions, hallucinations, and insomnia. Additional checkmarks indicated he was provided a calm environment, offered meaningful activities, was reapproached, and toileted without any changes in behavior. The clinical record lacked documentation where the event occurred, what event proceeded or precipitated the behavior, what staff were present, if any other residents were present, environmental considerations (such as temperature, noise, or lighting), a narrative description of what behavioral symptom the resident displayed, what resident specific interventions were attempted, and/or how long the behavior was exhibited. A 2/26/24 at 11:24 p.m. entry contained check marks in the columns for agitated, anxious/restless, [undefined] delusions, elopement/exit seeking, [undefined] hallucinations, insomnia/not sleeping, and refusing care. Additional checkmarks indicated he was provided redirected, removed from the situation, and provided a calm environment all without a change in behaviors. The clinical record lacked documentation of where the event occurred, what event proceeded or precipitated the behavior, what staff were present, if any other residents were present, environmental considerations (such as temperature, noise, or lighting), a narrative description of what behavioral symptom the resident displayed, what resident specific interventions were attempted, what care was refused, and/or how long the behavior was exhibited. During a 4/30/24 at 2:32 p.m. interview, the DON indicated The Behavior Monitoring and Intervention Report which contained checkmarks without additional narrative information was where behaviors were to be documented. The facility documented behaviors by exception only and if they were they resident's norm, they didn't require additional documentation. Only behaviors which were a danger to the resident and/or others needed greater detail. There was no other documentation to provide regarding the behaviors Resident 85 displayed in February prior to the behavior management team's determination to continue the antipsychotic medication, due to delusions and hallucinations. During an interview on 4/30/24 at 2:52 p.m., QMA 4 indicated they were familiar with Resident 85, who had displayed behaviors when having vivid dreams. When this happened, he reached for objects that were not present. Staff should always approach Resident 85 carefully if he was sleeping. The resident had not been displaying hallucinations or delusions. During an interview on 4/30/24 at 2:54 p.m., Activity Assistant 5 indicated they were familiar with Resident 85. The Activity Assistant had never witnessed the resident have delusions or hallucination. If she did, she would inform the nurse. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/24 at 2 :56 p.m., CNA 6 indicated they were familiar with Resident 85. The only behavior the resident displayed was reaching for objects that weren't there. Resident's usual behaviors were displayed in the clinical record. If a resident displayed a behavior that was new for that resident, staff filled out a form. If a behavior was dangerous, the nurse should be informed. During an interview on 4/30/24 at 2:58 p.m., LPN 7 indicated they were familiar with Resident 85. The resident some times reached for items that were not there. Resident 85 did not seem distressed by these objects. CNAs informed the nurse if a resident displayed a behavior that was concerning. Review of a current, November 2016, facility policy titled, Behavior Management, Prevention and Documentation, provided by the Administrator on 4/30/24 at 3:10 p.m., indicated the following: .It is the policy of [NAME] Retirement Community to identify mood and behavior symptoms that negatively affect residents, staff, or visitors. Mood and Behavior symptoms will be investigated to provide, or make referral to, appropriate interventions that prevent, contain, or manage such behaviors 3.1-37(a)

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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** 42685 Based on observation and interview, the facility failed to ensure medications were labeled with resident identifiers and directions for 2 of 5 medication carts reviewed. (Rehabilitation Cart 1 and Rehabilitation Cart 2) Findings include: 1. During an observation on 4/29/24 at 9:30 a.m., accompanied by QMA 20, the Rehabilitation Unit Medication Cart 2 contained an opened and unlabeled bottle of morphine sulfate oral solution (to treat pain) 100 milligram (mg)/5 Milliliters (ml), in the narcotic drawer. The bottle lacked identifiers and directions. During an interview, at the time of observation, QMA 20 indicated the opened bottle of morphine sulfate oral solution lacked a label or resident identification. She was uncertain why it was not labeled. All medications required labels regardless of where the medications came from. Medication labels were required to include the following: resident identifiers, drug name, drug dose, route of administration, and directions for use. She had not administered the medication, but was aware to whom the medication belonged to since she received the information in report. During an interview on 4/29/24 at 10:07 a.m., QMA 20 indicated she should have noticed the morphine bottle was not labeled when she did her controlled medication count at the beginning of her shift. 2. During an observation on 4/29/24 at 9:49 a.m., accompanied by QMA 20, the Rehabilitation Unit Medication Cart 1 contained the following opened and unlabeled medication bottles, without resident identifiers or directions for use: One orange bottle with a white lid contained the word aspirin hand written on the lid, One bottle of [NAME] pain reliever/caffeine 500 mg caplets, One bottle of COQ 10 (supplement) 200 mg softgels, One bottle of Turmeric Curcumin (supplement) capsules, One bottle of acetaminophen 250 mg capsules, One bottle of Tylenol arthritis pain extended release 650 mg capsules, One bottle of headache relief acetaminophen 250 mg capsules, One bottle of stool softener plus stimulant laxative 50 mg/8.6 mg capsules, One bottle of simethicone (gas relief) 125 mg bottle, and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	One bottle of apple cider vinegar (supplement) 450 mg capsules. During an interview, at the time of observation, QMA 20 indicated all of the bottles lacked resident identifiers and directions for use. The bottles should have been labeled immediately upon receipt. During an interview on 4/29/24 at 9:50 a.m., LPN 3 indicated she could not be certain to whom the medication bottles belonged to, since they were unlabeled in the medication carts. During an interview on 4/29/24 at 10:07 a.m., LPN 16 indicated all medications should have been labeled with resident identifiers, medication dosage, directions for use, and should have been labeled upon receipt before they were placed in the medication carts. Rehabilitation Medication Cart 1 contained medications for 10 residents. Rehabilitation Medication Cart 2 contained medications for 9 residents. A current facility policy, revised April 2019, titled Labeling of Medication Containers, provided by the DON on 4/30/24 at 11:14 a.m., indicated the following: . All medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations 3.1-25(j) 3.1-25(k)

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F 0839 Level of Harm - Potential for minimal harm Residents Affected - Many	Employ staff that are licensed, certified, or registered in accordance with state laws. 09676 Based on observation, interview, and record review, the facility failed to ensure an LPN employed to work in the facility in the nursing department had a valid Indiana nursing license or an active out of state license valid through an interstate compact agreement (LPN 3). This deficient practice had the potential to impact 164 of 164 residents who resided in the facility. Finding include: Employee records, completed by the facility, were reviewed on 4/29/24. LPN 3 was listed on the form as an LPN Supervisor. The form indicated the nurse had been employed by the facility since 2/27/23. A facility-provided binder containing nursing licenses verification for facility employees, indicated LPN 3 held a Texas Board of Nursing, License Type-LPN, Compact Status-Single State. The Texas Board of Nursing verification form, which listed single state had a run and print date of January 2024 (3 months prior to the review). During an interview on 4/29/24 at 1:30 p.m., the Human Resources Director indicated she would review the compact status of LPN 3 and provide additional information. The facility's nursing schedule for 4/24/24 through 5/1/24, provided following the entrance conference on 4/24/29, indicated LPN 3 was scheduled to work as a nurse supervisor, during an 8:30 a.m. to 5:00 p.m. shift, on 4/24/24, 4/25/24, 4/26/24, 4/29/24, 4/30/24, and 5/1/24. LPN 3 was observed on 4/29/24 at 2:31 p.m., providing wound care to a resident. During an interview on 4/29/24 at 4:26 p.m., the Administrator indicated LPN 3 had a Texas multi-state compact license when she applied for her position. Texas expected an individual to apply for a license by endorsement within 60 days after relocation. Therefore, Texas did change her license for Texas only. LPN 3 did not receive notice of this action. As of 4/29/24, LPN 3 had applied for Indiana license by endorsement. The nurse started employment at the facility in 2023 and had been working as a nurse unit manager since March of 2023. LPN 3 completed a wound treatment today, 4/19/24. The facility did not offer an explanation as to why clarification of the compact status had not been obtained following the January 4, 2024 printed verification, which indicated the employee had a Texas single-state license. A current, undated, facility policy titled Credentialing of Nursing Services Personnel, provided by the DON on 4/30/24 at 4:38 p.m., indicated the following: .8. A copy of the annual license renewal/certification (as applicable) must be resented to the Director if Human Resources: a. By October 31st in Odd years for RN's b. By October 31st in Even years for LPN's (continued on next page)

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F 0839 Level of Harm - Potential for minimal harm Residents Affected - Many	.employees are required to notify the Director of Human resources with any change to the status of licensure 3.1-13(b)

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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. 42685 Based on observation, interview, and record review, the facility failed to utilize infection prevention and control strategies to prevent contamination of wounds during wound care for 2 of 3 residents reviewed for skin conditions. (Residents 154 and 467) Findings include: 1. Resident 154's clinical record was reviewed on 4/26/24 at 10:57 a.m. Diagnosis included necrotic pancreatitis, generalized muscle weakness, and need for assistance with personal care. A current physician order, dated 4/9/24, indicated to cleanse the resident's abdominal wound from gastrostomy tube removal with normal saline and gauze, pat dry, and apply skin preparation every night. A current physician order, dated 4/23/24, indicated to provide a treatment to the abdominal wounds daily, as needed every night shift, and as needed for soilage and dislodgement. Cleanse the abdominal wounds with normal saline and gauze, pat dry, apply skin prep to periwound, and apply foam. A current physician order, dated 4/24/24, included Keflex (antibiotic) 500 mg capsule, give one capsule by mouth two times a day for seven days related to a wound infection. Review of the resident's admission Minimum Data Set assessment, dated 2/28/24, indicated the resident had moderate cognitive impairment and required substantial/maximal assistance from staff for bathing, personal hygiene, and rolling left and right. The resident had frequent urinary and bowel incontinence. Skin conditions included surgical wounds. Skin interventions included a pressure reducing device for the resident's bed and surgical wound care. The resident received antibiotic treatment for 7 out of 7 days during the assessment. A care plan, dated 2/22/24, indicated the resident was at risk for infection related to a surgical incision to the left side of abdomen from a tube placement present on admission and later removed. Interventions included the following: monitor site for signs and symptoms of infection such as redness, warmth, or drainage (2/22/24) and provide treatment per physician orders (2/22/24). A wound assessment, dated 4/23/24, indicated the left abdominal surgical incision was 0.3 centimeters (cm) length, 0.2 centimeters width, worsening, dehiscence x 2, purulent drainage noted, and suspected chronic infection. A wound assessment, dated 4/23/24, indicated the right abdominal surgical incision was 0.5 cm length, 0.3 cm width, worsening, dehiscence x 2, purulent drainage noted, and suspected chronic infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a wound care observation on 4/29/24 at 2:31 p.m., LPN 3 brought an overbed table (overbed table 2) to the resident's room from the nursing office with a bag of wound supplies, a marker, and a canister of disinfectant wipes. She used alcohol based hand rub (ABHR) upon entering the residents room, moved the resident's uncleaned overbed table (overbed table 3) away from the resident bedside and placed the black marker and disinfectant canister over onto the resident's uncleaned overbed table 3, without a barrier. Gloves were donned prior to disinfecting overbed table 2 when it was brought into the room for use during the wound care. Gloves were doffed, hand hygiene performed, gloves were donned, and wound supplies were placed unopened on overbed table 2. LPN 3 used both gloved hands to move overbed table 3 further out of the way. Without doffing her gloves or using hand hygiene, the foam dressing on the right side of the abdomen and a foam dressing on the left side of the abdomen were both removed and had a small amount of serousanguineous drainage noted the length of each open wound on the dressings. LPN 3 doffed the gloves, performed hand hygiene, donned clean gloves, opened a 4x4 gauze, saturated the gauze with wound wash, and cleansed the right abdominal surgical incision with her right gloved hand, opened another 4x4 gauze, saturated the gauze with wound wash, and cleansed the left abdominal surgical incision with her right gloved hand. Gloves were then doffed, hand hygiene performed, gloves donned, gauze pads opened, and both left and right abdominal incisions were patted dry with separate clean gauze pads. Without changing gloves or performing hand hygiene, the marker was pickup up from the surface of (uncleaned) overbed table 3 with the right gloved hand, the lid removed with the left hand, and dates written on both of the foam dressings. Without changing gloves and hand hygiene, the nurse picked up and opened the skin preparation for the wound treatment and used her right gloved hand to apply skin preparation to the right abdominal incision. Without changing gloves or performing hand hygiene, she opened another skin preparation and used her right gloved hand to apply skin preparation to the left abdominal incision. The dated foam dressings were then applied to each of the abdominal incisions with her gloved hands. Gloves were doffed, hand hygiene was performed, and disinfectant wipes were moved to overbed table 2 with the black marker and bag of wound supplies. During an interview on 4/30/24 at 11:37 a.m., LPN 3 indicated during the resident's wound care observation on 4/29/24, the contaminated marker should not have been handled with gloved hands, then continue wound care with skin preparation without changing gloves and performing hand hygiene. This caused a risk for potential infection related to contamination. 2. Resident 467's clinical record was reviewed on 4/26/24 at 10:06 a.m. Diagnoses included, unspecified fracture of thoracic 11 and thoracic 12 vertebra, subsequent encounter for fracture with routine healing, fusion of spine thoracic region, fusion of spine lumbar region, and obstructive and reflux uropathy. A current physician order dated, 4/17/24, indicated to provide back treatment every day shift. Cleanse the back with soap and water, pat dry, apply povidone iodine, and leave open to air. Review of the resident's admission Minimum Data Set assessment, dated 4/17/24, indicated the resident was cognitively intact and required substantial/maximal assistance from staff for toileting, bathing, dressing, and rolling left and right. An indwelling catheter was required and the resident had surgical wounds. A current care plan, dated 4/15/24, indicated the resident was at risk for skin impairment related to a ground level fall resulting in a lumbar 1 vertebra and thoracic 11 compression fracture. The resident admitted with multiple surgical incisions. Interventions included medications as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155655	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peabody Retirement Community	400 W Seventh St North Manchester, IN 46962

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a wound observation on 4/29/24 at 2:09 p.m., LPN 16 and LPN 3 performed hand hygiene upon entering Resident 467's room. LPN 16 and LPN 3 each donned gloves. After the overbed table was disinfected by LPN 16, her gloves were doffed and hand hygiene was completed. LPN 16 then donned clean gloves and set up wound supplies on the table. LPN 3 walked to the left side of the resident's bed to assist the resident onto his left side. With gloved hands, LPN 16 picked up the bed controller with her left gloved hand and used her right gloved hand to lower the head of the resident's bed to aide the resident in turning. Without changing gloves or performing hand hygiene, LPN 16 picked up the 4x4 gauze package and opened it with her right gloved hand. Without changing gloves or using hand hygiene, she saturated the gauze and used her right gloved hand to cleanse the 4 incisions on the right side of the spine. She used her right hand to pick up another saturated gauze and cleansed the incisions on the left side of the spine. A new gauze was not used for each incision. LPN 16's gloves were doffed after cleansing the incisions and hand hygiene was performed prior to donning clean gloves. Another package of 4x4 gauze was opened and the incisions were dried. LPN 16's gloves were doffed and hand hygiene performed prior to donning clean gloves. She opened the iodine sticks and applied iodine to the 8 incisions, and allowed it to dry before LPN 3 assisted the resident back onto his back. During an interview on 4/30/24 at 11:37 a.m., LPN 3 indicated she assisted LPN 16 during the resident's wound care treatment on 4/29/24. LPN 16 should not have used her gloved hands to touch the bed controller and continue with wound care cleansing prior to changing her gloves and performing hand hygiene. The was a risk for potential infection from contamination. During an interview on 4/30/24 at 5:02 p.m., the DON indicated hand hygiene was required prior to continuation with wound care when a contaminated surface was touched during a wound care treatment. A current facility policy, revised August 2019, titled Handwashing/Hand Hygiene, provided by the DON on 4/30/24 at 4:18 p.m., indicated the following: Policy Statement .This facility considers hand hygiene the primary means to prevent the spread of infections . Policy Interpretation and Implementation .2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 7. Use an alcohol-based hand rub containing at least 62 % alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .g. Before handling clean or soiled dressings, gauze pads, etc . k. After handling used dressings, contaminated equipment, etc . l. After contact with objects .in the immediate vicinity of the resident 3.1-18(a) 3.1-18(b)(2) 3.1-18(l)