STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165049	A. Building B. Wing	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Village	4130 Northwest Boulevard Davenport, IA 52806

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on clinical record review, resident and staff interviews, provider interview and facility policy review, the facility failed to provide a safe environment free from physical abuse for 1 resident (Resident #64). This resulted in harm to the resident in the form of a displaced fracture to the lower end of the right humerus and a non-displaced fracture to the head of the right radius. The facility reported a census of 55. Findings include: The Minimum Data Set (MDS) for Resident #64, dated 08/12/2025, documented the following diagnoses: Anemia, Atrial Fibrillation, Coronary Artery Disease, Hypertension, Cerebrovascular Accident (Stroke), and Non-Alzheimer's dementia. It further documented her hospice status. It failed to document osteopenia (mild bone loss) or osteoporosis (significant bone loss). It documented the resident's Brief Interview for Mental Status (BIMS) score as 06, indicating severely impaired cognition. The Care Plan for Resident #64, last revised 09/14/2025, documented both the radius and humerus fractures. It documented the residents need for one-person assistance for bed mobility and to get dressed. It documented Resident #64's cognitive impairment and identified behaviors such as calling out Mom/Dad, restlessness, and agitation. It instructed staff members to use caution when providing bed mobility or transferring the resident to avoid striking arms and hands on surfaces. It further instructed staff members that Resident #64 required moderate assistance when dressing her upper body. Review of the nursing progress notes revealed the following. On 09/04/2025: At 09:25 AM a late entry was made indicating a hospice nurse was presently evaluating Resident #64 due to a nursing report indicating the resident was shouting in pain. At 04:30 PM a pain assessment was completed stating the resident would scream whenever her right arm was even lightly touched. At 04:51 PM Staff N, Registered Nurse (RN), reported the resident's arm was swollen and distended and appeared painful. Resident was able to state she was in pain. Hospice was called to reevaluate the resident. At 06:06 PM the progress note indicated a Hospice nurse was again assessing the resident, it was noted the resident had a golf ball sized lump protruding from her right arm and became inconsolable if her arm was even lightly touched. The rest of the evening noted more of the same, with resident yelling out and screaming if her arm was even lightly touched. Hospice services refused X-Ray, and per family wishes the resident waited until the following morning for imaging.On 09/05/2025: At 04:30 AM Resident #64 became inconsolable and began yelling out, she was not able to be redirected or calmed down. At 05:32 AM Resident #64 had calmed down and was resting again. At 04:16 PM orders were obtained to get X-Ray images of the right arm. At 09:42 PM the facility medical director recommended sending Resident #64 to emergent discovery (ED) for further evaluation, and after speaking to the family they again requested the resident be allowed to rest for the evening under hospice care. On 09/06/2025: At 08:10 AM Resident #64 was sent to the emergency room for further imaging and assessment. At 01:45 PM progress note states the resident was confirmed to have a fractured radius and a displaced fractured humerus. Review of hospital documentation dated 09/06/2025 showed a significantly displaced fracture of the right humerus as well as a smaller secondary fracture to the right radius. In an interview on 10/01/2025 at 11:18 AM with Staff L, Certified Nurse Aide (CNA), she stated she was the second staff member to respond to Resident #64 on 09/04/2025. She stated she was getting another 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 0600 Level of Harm - Actual harm Residents Affected - Few	up for a shower when she heard Resident #64 crying out. She noted she was prone to crying out, but the screams made on the morning of 09/04/2025 were different. Shortly after the scream was heard, Staff Q, CNA, approached her and asked her for help. She was informed by Staff Q, Resident #64 was combative and was violently resisting cares. She requested aide. When Staff L entered Resident #64's room she found the resident half-dressed, and the resident began to scream and resist cares when Staff Q participated, attempting to get away from Staff Q. At one point in time during cares, the resident pointed at Staff Q and stated I don't want her in here, get her out!. Resident #64 did not resist cares with Staff L, though she cried out loudly when her right arm was touched. Staff L noted it was unlike Resident #64 to violently resist cares, and she had never seen the resident kick or lash out during cares. Throughout cares she noted Staff Q to be quiet, and felt she appeared cold and uncaring when Resident #64 was clearly in pain. After assisting the resident with cares, she told Staff Q to make a report to nursing. After she finished up another task Staff L reported to a nurse herself to find out Staff Q had only reported she was scratched by Resident #64 to the nurse. She also noted she had previously had issues with Staff Q's performance, and noted she always seemed to be in a rush. She also noted other residents had issues with her care, and provided the surveyor with the name of a resident who might remember Staff Q. In an interview on 10/01/2025 at 02:56 PM with Staff P, Licensed Practical Nurse (LPN), he confirmed he was the nurse who took report from Staff L and Staff Q on 09/04/2025. He stated he was aware of a situation, before either staff reported it to him, because he could hear Resident #64 scream that morning. He noted the resident often loudly cried out, but this scream was different. He noted he took report first from Staff Q, who only stated that she was scratched by Resident #64, which he felt was odd because he did not know the resident to violently resist cares. She stated she only cried out, often repeating Mommy daddy. After the report he told nurse management, who involved Hospice in her assessment. He further acknowledged he did not care for Staff Q, as he felt her cares were rough and quick and he had at least one resident complain. He stated he was preparing to make a report to nurse management about Staff Q when the incident occurred and she was removed from the facility. He stated in his professional nursing opinion, fractures of the severity seen in Resident #64 could not have occurred with a reasonable amount of force during cares. In an interview on 10/01/2025 at 03:11 PM with Resident #50, whose BIMS is noted as 15 indicating fully intact cognition, she stated she was familiar with Staff Q. She stated Staff Q doesn't listen to her and doesn't care, and moves too quickly and roughly which often causes her pain during cares. She stated she had tried to speak to Staff Q about the issues but she just does not listen to her. She stated she had recently talked to Staff P about the issues with Staff Q. In an interview on 10/01/2025 at 04:32 PM with Staff O, CNA, she stated she took report from Staff Q at shift change, and was only informed Resident #64 was resistive to cares. She stated she was familiar with the resident and had never known her to physically resist cares. She stated the resident was small and described her as frail, and posters in the resident's room instructed staff members to care for her gently as she did not have full use of her right arm following her strokes, but the resident never required force during cares as she did not resist. She stated after taking report she found a massive lump on the resident's arm and summoned nursing again because she felt it had been fractured, and was informed hospice had been called to assess the resident. In an interview on 10/02/2025 at 01:46 PM with Staff N, Registered Nurse (RN), she confirmed she was not in the facility when the incident initially occurred, but confirmed she did take report from Staff P about the situation and was very familiar with Resident #64. She stated she was told by Staff P something was wrong with the resident's arm, and that hospice had assessed but he felt the arm needed reassessment. She felt the resident's arm had been fractured. She stated the resident appeared frail, but never resisted cares. She would occasionally move away from things that caused her discomfort but never lashed out and kicked or hit at staff members. She stated in her professional nursing opinion, she does not believe that normal cares could have fractured the resident's arm so significantly. She stated she had cared for Resident #64 countless times and had always used what (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	she considered normal amounts of force which had never even resulted in the resident expressing discomfort. In an interview on 10/02/2025 at 12:58 PM with Staff M, RN, she stated she was familiar with Resident #64 and did not believe standard care practices could have resulted in a fracture of such magnitude. In an interview on 10/01/2025 at 12:23 PM with the Facility Medical Director, she stated she was very familiar with Resident #64 and had cared for her for some time, she noted the resident had been diagnosed in 2017 with age related osteopenia and noted the loss of some bone mineralization in the hospital findings, which could contribute to a fracture. She confirmed the findings of the Hospital imaging was consisted with a significant fracture of the humerus and a less severe fracture of the radius and was not consistent with a typical osteopenia fracture presentation. She stated based on her medical opinion, she could not make a judgement as to whether or not the fracture was intentional, but further noted the kind of trauma required to fracture the resident's arm would need to be dramatic. She further noted the amount of times the resident underwent standard cares such as dressing without any issue gave her caution as to whether or not simple dressing practices would have been enough to fracture the residents arm. She stated she had directly performed some cares on Resident #64 and had never had an issue with the resident violently resisting cares, pushing her away, or ever becoming violent. In an interview on 10/02/2025 at 08:49 AM with the Director of Nursing, she stated her expectation is for staff members to perform cares as gently as possible to avoid injuries to frail and elderly residents. She acknowledged staff members should never rush cares as it increases the likelihood of injury. She further acknowledged that standard nursing cares should never result in a fracture of the magnitude Resident #64 suffered, even with osteopenia or osteoporosis. She finally stated that in her professional nursing opinion, the fracture Resident #64 suffered could only have resulted from excessive force, which is why Staff Q was terminated. Review of a facility provided document titled Abuse Prevention, Identification, investigation, And reporting, with a last revised date of 06/26/2024, it identifies under key definitions subsection #9 that Neglect is the failure of the facility, its employee or service providers to provide goods and services to a resident that are necessary to avoid physical harm. The policy further states All residents have the right to be free from abuse and neglect.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and staff interviews the facility failed to store food properly, handle food correctly for 3 out of 3 meals observed and maintain clean refrigerator and microwave to prevent food borne illnesses. The facility identified a census of 55 residents. Findings include:1.) During the initial tour of the kitchen on 9/29/25 at 10:01 AM observed the following boxes open to air with plastic bags inside not sealed and not labeled or dated in the walk in freezer of the main kitchen:-Large bag of peas opened to air -Ice cream on cart 3 large containers lids not on tight, partially used and not dated- 5 gallon container of ice cream on shelf partially used and no lid on container - Peach Danish open - Croissants- Pizza dough- Gluten free pizza crust - Regular pizza crust - Tilapia- Catfish On 9/29/25 at 10:30 AM Staff F, Executive Chef stated all food in the walk-in freezer should be dated once opened and the bags should be sealed at all times. The ice cream should be covered. The facility provided a policy titled Food and Supply Storage with a revision date of 1/24 it directed all food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. The policy directed staff to cover, label and date unused portions and open packages. 2.) On 09/29/25 at 2:00 PM the refrigerator in 200 hall dining room had brown dried substance on the inside door and a dried purple substance on the first and second wire shelf, and on the inside right side of the refrigerator. The front of the refrigerator had brown runs and liquid spills dried on it. The microwave had dried brownish orange substance on the glass plate inside of it. The handle and the door had smears on it and run marks across the bottom of the front door of the microwave. The second refrigerator on the 200 hall dining room had orange substance in the bottom below the bottom shelf and the seal across the bottom of the refrigerator had dirt on it. On 09/30/25 at 11:55 AM the refrigerators and microwave in the dining room on the 200 hall observed unchanged from 9/29/25. The observation of spills and dried food remained on both refrigerators and microwave. On 10/02/2025 at 9:13 AM Staff H, Dietary Aide stated they are supposed to clean the refrigerators in the dining rooms after every shift and make sure it is stocked for the next meal. There is a check off sheet of what to do and what to wipe down. All food that is opened that goes in the refrigerator or freezer should be labeled and dated and should be covered. On 10/02/25 at 10:27 AM the Dining Room Manager stated after every shift the microwaves and refrigerators in each dining room should be cleaned out and wiped down. There is a check list for the staff to complete. On 10/02/25 at 10:58 AM the Director of Nursing, Registered Nurse (RN) stated regarding the refrigerators on the units that are nursing related she is not sure who is responsible for cleaning them. She stated they have temperature logs and the nursing staff takes care of them. The microwaves should be cleaned by dietary. They do not have cleaning logs but she would expect it to be clean. The facility provided a Health Center End of Shift Checklist undated which indicated refrigerator to be organized and spills wiped out and to clean the microwave. The facility failed to produce any logs filled out by staff. 3.) During a continuous observation of meal service in the dining room on Unit one on 09/29/25 at 11:42 AM to 12:24 PM Staff G, Dietary Aide washed hands, donned gloves and proceeded to serve residents plates of food touching counters, cabinets and dietary slips. She then would pick up eggrolls with gloved hands and place on plate and cut in half. During the meal service she used the top of her shirt to wipe her face and wiped her face with shirt sleeve. Dietary staff failed to wash her hands or change her gloves during the meal service and continued to pick up eggrolls with gloved hands and place on plate. During the meal service she retrieved bread and touched with gloved hands. Staff G also served soup she touched the inside of the bowls before placed soup inside the bowls.On 09/30/25 8:30 AM Staff H, Dietary Aide served breakfast in dining room on unit one. The dietary aide served breakfast wearing gloves, touched diet slips, counters and utensils, she used gloved hands to touch the French toast to cut in half, removed gloves, did not wash hands and put on a new pair of gloves and touched trays, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	diet slips and utensils plated food and picked up toast with hands and cut in half on the plate. On 10/1/25 at 12:15 PM Staff I, dietary aide served lunch in the 300 hall dining room. She used gloved hands to touch the sweet potatoes served to residents and after placed on plate used gloved hands to cut in half. She failed to change gloves in between plates, she touched utensils, counters and diet slips. Staff I took cold turkey sandwich out of refrigerator and picked up with gloved hands to put on another plate. During the meal service Staff J, Dietary Aide used gloved hands to pick up cookies and place on individual plates after touching the counters and cabinets. Staff failed to change gloves during the meal service. On 10/02/25 at 9:09 AM Staff H, Dietary aide stated they had education on food handling, I think we had it once. She reported when wearing gloves we can touch the food if we have to. I have tongs, I also use those most of the time. She stated you can use gloved hands to touch the food but not if I have touched other things in between then would have to wash her hands and change gloves. On 10/02/25 at 10:18 AM Staff F, Executive Chef stated the expectation for every place is different with policy with handwashing and glove usage. The best practice is if you are handling food it needs to be handled with a fresh pair of gloves. If plating food, need to take gloves off wash hands and put on fresh pair of gloves. I would say even if plating cold food need to take gloves off and wash hands. On 10/02/25 at 10:44 AM the Director of Dietary stated the expectation is the staff should not be touching food after touching anything else with gloves on and should wash hands in between touching things and put on a new pair of gloves.The facility provided a policy titled Food Handling Guidelines with date revised 1/24 it directed single use disposable gloves are worn when preparing foods that will not be cooked again (ready-to-eat-foods) and while serving food. Gloves are to be placed over clean hands. Gloves are changed between tasks or if punctured or ripped. Hands are washed after gloves are removed.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on the previous Center for Medicare and Medicaid Services (CMS) Statement of Deficiencies forms, staff interview, current CMS Statement of Deficiencies form and facility policy review the facility failed to carryout Quality Assurance (QA) activities to prevent reoccurrence of deficiencies. The facility reported a census of 55 residents. Findings include: Review of the CMS 2567 report dated 9/26/24, included deficiencies related to F0865 (QAPI Program/Plan, Disclosure/Good Faith Attempt) at a D, F0812 Food Procurement, Store/Prepare/Serve-Sanitary, F0868 QAA Committee, and F0880 Infection Prevention & Control. The survey dated 10/2/25, included deficiencies related to F0865 (QAPI Program/Plan, Disclosure/Good Faith Attempt) at a D, F0812 Food Procurement, Store/Prepare/Serve-Sanitary, F0868 QAA Committee, and F0880 Infection Prevention & Control. On 10/02/2025 at 12:49 PM the Director of Nursing (DON) reported the facility worked on the previously cited deficiencies. The facility provided the QAPI Plan dated 8/25/17, that reflected oversight of the QAPI program is provided through a committee structure that is accountable to the facilities Executive Leadership. The leadership team and QAPI Steering Committee have the responsibility for planning, designing, implementing, and coordinating consumer care and service and selecting QAPI activities to meet the needs of residents and families.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on staff interviews, facility sign-in sheets and facility policy, the facility lacked the required Infection Preventionist (IP) at 3 of the 4 quarterly meetings. The facility reported a census of 55 residents. Finding include: Review of the Quality Assurance Process Improvement (QAPI) quarterly sign-in sheets dated 1/22/25, 4/23/25, and 7/23/25 lacked the IP in attendance. On 10/02/2025 at 12:49 PM the Director of Nursing (DON) reported Staff A, prior Assistant Director of Nursing (ADON) failed to attend the meetings. The DON reported she started here November 11th, 2024. The facility provided the QAPI Plan dated 8/25/17, that reflected oversight of the QAPI program is provided through a committee structure that is accountable to the facilities Executive Leadership. The leadership team and QAPI Steering Committee have the responsibility for planning, designing, implementing, and coordinating consumer care and service and selecting QAPI activities to meet the needs of residents and families. The facility provided a Key Personal list that included an IP.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews and facility policy review the facility failed to complete dialysis site assessments before and after dialysis for 1 of 1 residents reviewed (Resident#11). The facility reported a census of 55 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] listed diagnoses of dependence of renal dialysis, end-stage renal disease, and diabetes mellitus (DM). The Brief Interview for Mental Status listed a score of 15, intact cognition. The Care Plan for Resident #11 dated 5/30/25, reflected she needed dialysis related to renal failure. The Care Plan directed staff to monitor/document/report as needed (PRN) any signs or symptoms (s/s) of infection to access site: redness, swelling, warmth or drainage. Monitor/document/report PRN for s/s of the following: bleeding, hemorrhage, bacteremia, and septic shock.The Medication Administration Record (MAR) dated 9/25, directed vital signs before and after dialysis appointment two times a day every Monday, Wednesday, and Friday. The MAR failed to direct nursing staff to assess her left arm for s/s of bleeding or the bruit and thrill. The Progress Notes for Resident #11 dated 9/1/25-9/30/25, lacked assessment of her left arm for s/s of bleeding or the bruit and thrill.The Assessment in the Electronic Health Record (EHR) dated 8/2/25 through 10/1/25 lacked dialysis assessments. On 09/29/2025 at 1:58 PM Resident #11 reported the staff check her vitals but they failed to check on the dialysis site for bleeding, failed to feel (thrill) or listen (bruit). On 10/02/2025 at 9:46 AM Staff D, Registered Nurse (RN) reported the dialysis assessments include listen to thrill, complete before and after vitals. She said the assessments are under the notes of dialysis under assessments in the EHR. On 10/02/2025 at 10:00 AM the Infection Preventionist (IP) reported dialysis assessment are for staff to check and make sure she's not bleeding.On 10/02/2025 at 10:45 AM the Director of Nursing (DON) reported the dialysis process needed work. The DON said at minimum nursing needed to check her when she gets back form dialysis. The facility provided a policy titled End-Stage Renal Disease, Care of Resident with dated 9/2010, failed to direct assessment of the access site.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews and facility policy review the facility failed to implement Enhanced Barrier Precaution (EBP) for 2 out of 6 residents reviewed (Resident #2 and 11). The facility reported a census of 55 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] listed diagnoses of dependence of renal dialysis, end-stage renal disease, and diabetes mellitus (DM). The Brief Interview for Mental Status listed a score of 15, intact cognition. The MDS identified Resident #11's pressure ulcer. The Care Plan for Resident #11 dated 7/5/25 revealed a pressure ulcer to right foot, pressure ulcer to left foot and followed by the wound center. The Care Plan dated 8/21/25 directed Enhanced Barrier Precautions will be in place for the duration of the residents stay or until a wound is resolved or the indwelling medical device is discontinued. The Progress Note dated 9/28/25 at 6:24 AM, revealed left heel pressure ulcer length 0.5 centimeter (cm) by 0.4 width and depth 0.1 cm. The Medication Administration Record dated 9/25, directed vital signs before and after dialysis appointment two times a day every Mon, Wed, and Fri. On 9/29/2025 at 1:50 PM Resident #11's room door failed to show an EBP sign. Resident#11 lay in bed while Staff B, Certified Nurse Aid (CNA) and Staff C, CNA provided incontinent care and transferred Resident #11 to her recliner. Both Staff B and Staff C failed to wear EBP. On 09/29/2025 at 1:58 PM Resident #11 reported the staff who come in and care for her failed to wear any EBP with any cares. On 10/02/2025 at 9:46 AM Staff D, Registered Nurse (RN) reported residents need EBP for cares if they have large open wound, foley catheter, colostomy, ostomy, tube or drains. She reported not for dialysis because she has no protocol in place that directed EBP. On 10/02/2025 at 10:00 AM the Infection Preventionist (IP) reported Resident #11 failed to need EBP. The IP said Resident #11 lacked a would or other requirement to need EBP. The IP reported a dialysis port not a reason for EBP. On 10/02/2025 at 10:10 AM Staff E, RN reported Resident #11's wound is from pressure and she went to the wound clinic for care. On 10/02/2025 at 10:24 AM the IP reported when a residents wound is open that required a dressing the resident needed EBP. The facility provided a policy titled EBP dated 7/12/2022, it is the policy of this facility that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as a resident with wounds, indwelling medical devices or residents with infection or colonization with an MDRO. Enhanced Barrier Precautions require gown and glove use for residents with a novel or targeted (continued on next page)

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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	MDRO or any resident with a wound or indwelling medical device during specific high-contact resident care activities. Example: Transferring, Providing hygiene, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing. Gown and gloves are not necessary for resident care activities other than those listed above. 2. The Quarterly MDS for Resident #2, dated 06/25/2025, documented diagnoses of anxiety, malnutrition, and the presence of an abdominal feeding tube (G-tube). The Brief Interview for Mental Status listed a score of 15, indicating intact cognition. The Care Plan for Resident #2, last revised on 10/01/2025, identified the abdominal feeding tube and instructed staff members to utilize Enhanced Barrier Precautions (EBP) for the duration of the residents stay or until the remove of the abdominal feeding tube. It stated EBP required disposable gloves and a gown to be worn during use or care of the resident's feeding tube. In a direct observation on 09/30/2025 at 09:31 PM, Staff K, Registered Nurse (RN), was observed performing the tube feeding for Resident #2. During the feeding, Staff K was observed not to use enhanced barrier precautions despite the personal protective equipment kit being placed outside of Resident #2's door, and a sign on Resident #2's door instructing staff to wear EBP while caring for the resident. In an interview on 09/30/2025 at 09:57 AM, Resident #2 stated the staff members never wear gowns with him when performing cares, and he was unsure what enhanced barrier precautions were. In an interview on 10/02/2025 at 12:52 PM with Staff L, Certified Nurse Aide (CNA), she stated it was her understanding EBP should be worn when performing cares for residents with a catheter or a wound, but she was unsure if she was required to wear it if performing cares for a resident with an indwelling feeding tube. She stated she would always wear it out of precaution if the resident had a feeding tube. In an interview on 10/02/2025 at 12:58 PM with Staff M, RN, she stated that all indwelling medical devices, such as catheters or feeding tubes, as well as any resident with an open wound requires enhanced barrier precautions to be worn when providing care for the resident in their room. She stated it would not be required if they were helping a resident down the hallway. In an interview on 10/02/2025 at 08:49 AM with the Director of Nursing (DON), she stated her expectation was for Staff K to have worn EBP as directed by the care plan, and the posting outside of the resident's room. She further stated it had been an area of ongoing education for CNAs, but as a direct result of the survey more education would be provided to Nurses as well.