STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Lutheran Home	2027 College Avenue Elk Horn, IA 51531

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, family interview, staff interview, and policy review the facility failed to ensure 1 of 5 residents personal property was protected from loss or theft (Resident #14). The facility reported a census of 49 residents. Findings include: Review of Resident #14's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 99 indicating the resident was unable to perform the interview. The MDS further revealed diagnoses of progressive neurological conditions, cancer, non-Alzheimer's dementia, depression, and altered mental status. Interview 6/23/25 at 1:34 PM with Resident #14's family member revealed that Resident #14 was missing her wedding ring, and a birthstone ring. The family member then revealed that the facility was aware, and had not replaced the items. The family member further revealed that the rings were missing a couple months ago, and had notified the facility. Review of a facility provided document titled, Inventory of Personal Effects with a signature date of 8/13/18 revealed an entry under the jewelry section of the form saying ring, and watch. Review of the Electronic Healthcare Record (EHR) page titled, Progress Notes revealed an entry 4/30/25 at 1:41 PM that Social Services spoke with Resident #14's Family member about missing items and an investigation. Further review of this entry revealed that Social Services was going to speak with the Administrator and will follow up with Resident #14's family member on how to move forward. Further review of the Progress Notes revealed another entry 4/30/25 at 2:57 PM revealing Social Services had informed Resident #14's family member they had spoken with the Administrator, and the family member was welcome to proceed with filing with the sheriff's department. The entry further revealed that the facility would continue to look for the lost items. Interview 6/25/25 at 8:52 AM with Social Services revealed that She did file a grievance for the missing items for Resident #14, and that the items were never found or replaced. Social Services further revealed that inventory sheets should be completed at admission and updated at Care Plan meetings. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview 6/25/25 at 10:22 AM with the Director of Nursing (DON) revealed that inventory sheets should be updated and correct as this was an expectation. The DON further revealed that her expectation would be for items to be replaced if lost. Review of a facility provided undated policy titled, Inventory of Personal Effects revealed: a. Inventory of personal effects should be completed on admission, and updated as new articles are acquired.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on document review, staff interviews, and the facility policy review, the facility failed to implement the abuse and neglect policy by not completing background checks prior to staff employment for 1 out of 5 staff reviewed. The facility reported a census of 49 residents. Findings include: A review of personnel file of Staff G, Licensed Practical Nurse (LPN), revealed the background check was completed 3/15/25 while the hired date was 10/8/24. Background check was not completed prior to hire date. In an interview with Staff H, Human Resources, on 06/24/25 02:29 pm, she stated during an internal audit they didn't locate a background check on Staff G, LPN and they completed one immediately on 3/15/25. During an interview with the DON on 6/24/25 at 2:35 pm, she confirmed that the facility failed to complete a required background check prior to hiring Staff G. Review of the facility provided policy titled Abuse and Neglect-Rehab/Skilled, Adult Day Services, Therapy & Rehab revised 4/7/2025 documented: The location will not knowingly employ or otherwise engage individuals who have been found guilty of abusing, neglecting, exploiting, misappropriating property or mistreating residents/clients by a court of law or have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents/clients or misappropriation of their property or have a disciplinary action in effect against his or her professional license by a state licensure body as result of a finding of abuse, neglect, exploitation, mistreatment of residents/clients or misappropriation of resident/client property.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on electronic health record review, resident interview, personnel file review, facility policy review, and staff interview the facility failed to investigate and report alleged violations related to mistreatment to officials including the State Survey Agency in an appropriate time frame for 1 of 1 residents (Resident #37). The facility reported a census of 49 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] documented Resident #37 had a Brief Interview for Mental Status (BIMS) of 12 indicating moderate cognitive impairment. The MDS reflected Resident #37 diagnoses of cerebrovascular accident (CVA), transient ischemic attack (TIA) or stroke, hemiplegia or hemiparesis, and diabetes mellitus. The MDS further documented Resident #37 required total dependence of staff for performing toilet transfers and toileting hygiene. During interview on 6/24/25 at 11:16 am Resident #37 stated Staff F, Certified Nursing Assistant (CNA) was providing cares to her before bed time on 2/5/25 and left her on the bed pan for 5 hours without the call light within reach. Resident #37 revealed a few days later Staff F returned to work, was providing cares to her again and was not respectful during the interaction. When Resident #37 asked for a blanket, Staff F was talking over the resident and was not picking out the right blanket. She became frustrated and threw the pile of blankets on the resident's lap and told her to pick the one she wanted. Resident #37 stated Staff F was acting drunk. Resident #37 stated she told Staff F to leave the room and she did. Resident #37 further revealed she did not report Staff F to the management out of fear that Staff F was friends with the Director of Nursing but she spoke with one of the nurses after the incident who is now the Director of Nursing (DON) but at that time was in a different role at the facility and was told steps will be taken. Resident #37 reported she has not had Staff F provide any further cares to her and most likely no longer worked at the facility. A review of the Electronic Health Record (EHR) for Resident #37 lacked documentation of the 2/5/25 events regarding Staff F left Resident #37 on the bed pan without a call light for 5 hours and no assessments were documented on the cognitive or physical condition of the resident following the incident. A review of the Facility Reported Incidents to the State Agency for Resident #37 did not return results that the facility reported an incident between the resident and Staff F. During an interview with the DON on 6/24/25 at 2:35 pm who took the position less than 3 months ago, stated to her knowledge there was no investigation completed by the previous administration about Resident #37 incident that occurred in February. She confirmed the administration was aware about the events as they were discussed during the routine management meetings. She also confirmed she did not file a report of possible abuse to the State Agency as she believed the previous administration was working on it. The DON also stated that she expected her staff to report any abuse allegations to the management within 2 hours and the management or staff have the knowledge how to report abuse and the reporting information is posted by the time clock. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Staff F personnel file document titled Corrective Action Notice dated 3/7/25 documented last day of employment 3/7/25 with the reason for termination due to lack of attendance. Review of the facility provided policy titled Abuse and Neglect-Rehab/Skilled, Adult Day Services, Therapy & Rehab revised 4/7/2025 documented: Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator. In the absence of the administrator from the location, the following individuals have the administrative authority of the administrator for purposes of immediate reporting of alleged violations: the director of nursing services or the supervisor of social services. These designated individuals are delegated the authority by the administrator to: 1. Intervene in any situation in order to protect residents. 2. Remove any individual from the location if necessary for the protection of residents/clients or employees, including but not limited to employees, visitors, contractors or family members. 3. Call local law enforcement for assistance with interventions necessary for the protection of residents or employees. 4. Call 911 for any type of emergency assistance. PROCEDURE 1. If an employee receives an allegation of abuse, neglect, exploitation or misappropriation of resident/client property or witnesses suspected abuse, neglect or misappropriation of resident/client property, the employee will take measures to protect the resident/client, provided the safety of the employee is not jeopardized. The employee will then report the allegation to a supervisor. 2. The program coordinator, charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required and complete an initial investigation. If this is an injury of unknown origin, he or she also will attempt to determine the cause of the injury. The coordinator or charge nurse also will ensure that any potential for further abuse is eliminated by taking one of the following actions: 3 b, If this is an allegation of employee to resident/client abuse, the employee will be removed from providing direct care to all residents/clients. Additionally, the employee will be placed on suspension pending the results of the internal investigation. Another employee will be assigned to complete the care of the resident/client. c. Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency. If applicable, Adult Protective Services will be notified where state law provides for jurisdiction in long-term care centers. i. If there is an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident/client property, and/or there is serious bodily injury, then it will be reported immediately, but not later than two hours after the allegation is made.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to refer 2 residents with a negative Level I result for the Pre-admission Screening and Resident Review (PASRR), who were later identified with newly evident or possible serious mental disorder, intellectual disability, or other related condition, to the appropriate state-designated authority for Level II PASRR evaluation and determination for 2 out of 2 residents reviewed for PASRR requirements (Resident #16, #20). The facility reported a census of 49 residents. Finding include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #16 documented a Brief Interview for Mental Status (BIMS) did not indicate a summary score. The MDS documented an admission date of 6/14/23. The MDS documented high-risk drug classes use and indicated Resident #16 was taking antipsychotic, antianxiety, antidepressant, and anticonvulsant medications. The Electronic Health Record (EHR) documented Resident #16 had the following diagnoses: psychological insomnia, major depressive disorder, schizotypical disorder, and anxiety disorder. During the EHR review for Resident #16, no current PASRR Level II was located. In an interview with the DON on 6/25/25 at 9:10 am, she confirmed Resident #16 did not have a PASRR Level II since admission to the facility. 2. Review of Resident #20's MDS dated [DATE] revealed a BIMS score of 14 indicating intact cognition. The MDS further revealed diagnoses of progressive neurological conditions, anxiety disorder, depression, psychotic disorder, and non-Alzheimer's dementia. Review of a facility provided document titled, Notice of PASRR (Pre-admission Screening and Resident Review) level 1 screen outcome dated 10/28/21 revealed no active diagnosis for psychosis or visual hallucinations. The document further revealed should there be an exacerbation related to mental illness or a discrepancy in the reported information, a status change should be submitted for evaluation. Review of the EHR page titled, Medical Diagnosis revealed diagnosis of major depressive disorder with a date of 11/2/21, unspecified psychosis not due to a substance or known psychological condition with a date of 11/27/23, and visual hallucinations with a date of 5/19/25. Interview 6/25/25 at 8:17 AM with Staff C Social Services revealed that another PASRR should have been completed. Staff C then revealed the expectation would be that the PASRR be completed again with a new diagnosis. Interview 6/25/25 at 11:04 AM with the Director of Nursing (DON) revealed her expectation would be for PASRR assessments to be completed correctly. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility provided policy titled, Pre-admission Screening and Resident Review (PASRR) with a revision date of 12/30/24 revealed: a. If the resident is diagnosed with a mental disorder while in the location, social services, or the designated individual, will contact the designated state agency for a Level II screening.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, the facility failed to provide quality of nursing care by leaving a resident on a bed pan for an extensive period of time without a call light and not documenting the event for 1 of 1 residents reviewed (Resident #37). The facility reported a census of 49 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] documented Resident #37 had a Brief Interview for Mental Status (BIMS) of 12 indicating moderate cognitive impairment. The MDS reflected Resident #37 diagnosis of cerebrovascular accident (CVA), transient ischemic attack (TIA) or stroke, hemiplegia or hemiparesis, and diabetes mellitus. The MDS further documented Resident #37 required total dependence on staff for performing toilet transfers and toileting hygiene. During an interview on 6/24/25 at 11:16 am Resident #37 stated Staff F, Certified Nursing Assistant (CNA) was providing toileting hygiene on 2/5/25 and left her on the bed pan for 5 hours without a call light within reach. Resident #37 voiced with teary eyes she was laying in bed in a lot of pain and no once came to check on her during the night while she was on the bed pan and she was hurting. She located a call light in the drawer of the nightstand after 5 hours and pressed it for staff assistance. Staff came in and assisted her off the bed pan. Resident #37 revealed she reported it to a nurse and the facility installed an additional call light above the bed. A review of the Electronic Health Record (EHR) for Resident #37 lacked documentation of the 2/5/25 events regarding Staff F leaving Resident #37 on the bed pan without a call light for 5 hours and no assessments were documented on the cognitive or physical condition of the resident following the incident. During an interview with the DON on 6/24/25 at 2:35 pm confirmed the incident was brought up to her by Resident #37 and other staff knew and also the EHR for Resident #37 lacked documentation about the incident and lacked documented health assessments. She confirmed the administration was aware about the events as they were discussed during the routine management meetings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of Resident #8's MDS dated [DATE] revealed a BIMS score of 13 indicating intact cognition. The MDS further revealed Resident #8 utilizes oxygen therapy. Review of Resident #8's EHR page titled, Physician's orders revealed an order for oxygen 1 Liters Per Minute (LPM) per nasal cannula at night while sleeping. Interview 6/23/25 at 1:02 PM with Resident #8 revealed that she just puts the oxygen on, and is unsure how often the tubing is changed. Observation 6/23/25 at 1:02 PM oxygen tubing was noted to be dated 4/16/25, and humidification bottle was noted to be dated 4/23/25. Interview 6/24/25 at 10:37 AM with Staff A RN (Registered Nurse) revealed she works here every other weekend with an agency, and oxygen tubing is to be changed weekly on Wednesdays. Staff A then revealed that there is a book that shows oxygen tubing is to be changed weekly on Wednesday nights. Review of an undated facility provided document titled, Master Schedule 6p-6a Center Nurse, revealed Wednesdays oxygen tubing and nebulizer tubing are to be changed. No sign off sheets for oxygen being completed. Interview 6/24/25 at 10:44 AM with Staff B revealed that oxygen tubing is to be changed weekly, and that night watch completes this. Staff B further revealed that there is a book at the nursing stations and provided the book, but could not provide a sign off sheet. Interview 6/24/25 at 10:49 AM with the Director of Nursing (DON) revealed that oxygen tubing should be changed weekly, and this would be her expectation. Review of a facility provided policy titled, Oxygen Administration with a revision date of 7/28/24 revealed: a. Disposable equipment should be changed weekly or according to manufacturer's instruction and marked with date and initials. Based on observations, electronic health record (EHR) reviews, staff interviews, and policy review, the facility failed to provide respiratory care and services in accordance with professional standards of practice for 2 of 2 residents reviewed, requiring the use of oxygen (Resident #32, Resident #8). The facility reported a census of 49 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #32 dated 4/1/25 identified a Brief Interview for Mental Status (BIMS) score of 9/15 indicating moderate cognitive impairment. The MDS documented diagnoses that included: coronary artery disease (CAD), heart failure, renal insufficiency, diabetes mellitus, venous insufficiency (chronic) peripheral, obstructive sleep apnea, and shortness of breath. The MDS documented Resident #1 required oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #32's Care Plan dated 6/25/25 identified a focus area of oxygen therapy related to congestive heart failure. Interventions for staff included oxygen therapy as needed per order. The 6/25 Medication Administration Record (MAR)-Treatment Administration Order (TAR) did not provide orders or instructions for changing oxygen tubing. On 6/23/25 at 1:32 PM Resident #32 stated he used oxygen whenever he needed it and he was able to put it on himself. Observation on 6/23/25 at 1:32 PM observed oxygen tubing wrapped on top of the oxygen concentrator. The tubing was not dated. Observation on 6/24/25 at 8:30 AM observed undated oxygen tubing on top of the oxygen concentrator. EHR Clinical Physician Orders revealed an order written on 6/24/25 to change oxygen tubing, label with the date every Wednesday night, at bedtime every Wednesday for oxygen; a revision date of 6/24/25 and start date of 7/2/25.

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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** 2. Review of Resident #9's MDS dated [DATE] revealed an admission date to the facility from a short-term general hospital stay 5/13/24. The MDS further revealed Resident #9 utilizes an indwelling catheter. Review of Resident #9's EHR page titled, Clinical Physician ' s Orders revealed an order for coudé (a type of urinary catheter with a curved or bent tip) catheter for infection control with a date of 4/22/25. Observation 6/25/25 at 11:06 AM Staff D Certified Nursing Assistant (CNA) brought Resident #9 into the bedroom to empty Resident #9's catheter drainage bag. Staff D then donned a gown and gloves with no hand hygiene. Staff D then obtained a urine graduate and placed it on a barrier on the floor. Staff D then drained the drainage bag without cleaning the drainage port of the drainage bag. After the drainage bag was emptied Staff D cleansed the drainage port with an alcohol wipe. Staff D then emptied the graduate. Staff D donned the gloves and gown with no hand hygiene and left the room. Interview 6/25/25 at 12:46 PM with the Infection Preventionist (IP) revealed that hand hygiene should be completed, and EBP should be worn at appropriate times. This is expected during catheter care, and wound care. Interview 6/25/25 at 1:05 PM with the Director of Nursing (DON) revealed that hand hygiene should be completed, and EBP should be worn at the appropriate times. The DON further revealed that hand hygiene and EBP should be at the appropriate times during catheter care, and wound care. Review of a facility provided policy titled, Hand Hygiene with a revision date of 3/29/22 revealed: a. All employees in patient care areas will adhere to the 4 Moments of Hand Hygiene and 2 Zones of Hand Hygiene. 1. Entering Room 2. Before Clean Task 3. After Bodily Fluid/Glove Removal 4. Exiting Room 5. Zones: Patient zone and Health-care zone Review of another facility provided policy titled, Standard, Enhanced Barrier, and Transmission-Based Precautions with a revision date of 4/6/25 revealed: a. Enhanced barrier precautions are also used for residents with chronic wounds (i.e., pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers) and residents with indwelling medical devices (i.e., central lines, hemodialysis catheters, indwelling urinary catheters, feeding tubes, and tracheostomies), even if the resident is not known to be infected or colonized with a multi-drug resistant organism (MDRO). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	High-contact resident care activities include transfers, dressing, assisting during bathing, providing hygiene, changing briefs or assisting with toileting, working with resident in therapy gym (specifically when anticipating close physical contact while assisting with transfers and mobility), changing linens, device care or use (central line, urinary catheter, feeding tube, tracheostomy), and wound care. Based on observation, Electronic Health Record (EHR) reviews, staff interviews, and policy reviews the facility failed to implement appropriate hand hygiene and infection control practices to mitigate the spread of pathogens during resident cares for 2 of 3 residents (Resident #32, Resident #9). The facility failed to utilize hand hygiene, appropriate glove use, maintain clean and dirty environment/practices, and Enhanced Barrier Precautions (EBP). The facility reported a census of 49 residents. 1. The Minimum Data Set (MDS) for Resident #32 dated 4/1/25 identified a Brief Interview for Mental Status (BIMS) score of 9/15 indicating moderate cognitive impairment. The MDS documented diagnoses that included: coronary artery disease (CAD), heart failure, renal insufficiency, diabetes mellitus, venous insufficiency (chronic) peripheral, obstructive sleep apnea, and shortness of breath. The document revealed the resident had venous and arterial ulcers, application of non-surgical dressings, and application of dressings to feet. Resident #32's Care Plan dated 6/26/26 revealed a Focus Area for impaired skin integrity with a revision date of 6/19/25. The Interventions on the Care Plan for staff included a history of wound care orders with the current wound care to bilateral lower extremities (BLE) three times daily (TID) and as needed (PRN) for saturation. Clean BLE with wound cleaner, apply Hydrofera Blue to weeping areas, abdominal (ABD) pads, and gauze with a revision date of 6/26/25. A Focus Area for EBP related to wounds and wound care to BLE revealed Interventions for staff to don gown and gloves when performing high contact care activities including: dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking and changing, device care and/or use, and wound care with an initiation date of 6/25/25. The 6/25 Treatment Administration Record (TAR) revealed wound care to BLE TID for saturation. Clean BLE with wound cleaner, apply Hydrodera Blue to weeping areas, ABD pads, and gauze with a start date of 6/23/25, The document also contained an order for PRN cleanse any open areas to buttocks with wound spray then foam bordered dressing; change every 2-3 days or PRN for loosening or drainage with a start date of 3/11/25. Observed on 6/23/25 at 1:30 PM signage for EBP on Resident #32's door. Continuous observation on 6/25/25 at 7:18 AM of Staff E, Licensed Practical Nurse (LPN), completing Resident #32's BLE wound care with the Infection Preventionist (IP) present. A. Staff E in the resident's room with gown on and donning gloves. Staff E stated had completed washing her hands just prior to donning gloves. B. Staff E stated the resident had just come from the shower and did not require the use of wound cleaner. C. Staff E had supplies in a plastic wash basin on the table. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Lutheran Home	2027 College Avenue Elk Horn, IA 51531

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. The resident elevated his legs with the use of the recliner. E. Staff E opened the ABD package and placed it on an incontinence pad on her lap. F. The Hydrofera Blue Classic pads were opened, 3 individual packages, and placed on the resident's right lower extremity (RLE). The staff removed one of the pads, placed it on her lap, and then replaced it on the resident's leg. G. The ABD pads were taken from the staff's lap and placed on the Hydrofera Blue Classic pads. The Kerlix (gauze) was opened and wrapped around the resident's RLE. H. The staff placed tape to secure the Kerlix, donned the resident's gripper sock, and slipper. The bandage was not dated. I. Staff E proceeded to the left lower extremity (LLE) touching the leg, looking at the wounds, and at a new area where the resident complained of pain. J. Staff E stopped, removed gloves, moved the gown to access hand sanitizer on scrubs, and donned new gloves. K. Staff E started opening 2 packages of Hydrofera Blue Classic pads and placed them on the resident's LLE. L. The staff opened an ABD pad package and tucked under her arm, while trying to manage the Hydrofera Blue Classic pads. The staff stated she sometimes brings a Certified Nurses Assistant (CNA) to assist with holding bandages, and requested the IP to assist with holding bandages. M. The IP completed hand hygiene, donned gloves and gown to assist. Staff E stated she didn't realize the IP would need to wear a gown to assist. N. The IP held the Hydrofera Blue Classic pads in place while Staff E placed the ABD pad. Staff E obtained the Kerlix gauze, dropped the package on the floor, picked it up and continued to open it, and wrapped the resident's LLE. O. Staff E placed the resident's gripper sock and slipper on the LLE without dating the bandage. P. Staff E removed the gown and gloves, and completed hand hygiene. Q. Resident #32 complained of pain on his buttocks and requested his PRN patches. Staff E donned gloves, looked at the resident's buttocks, obtained patches from his wound care dressing drawer, and placed 2 patches. R. The resident continued to request a third patch. Staff E looked at the area the resident was touching and stated there was no area that was compromised, but agreed to place a patch. The staff removed her gloves, went to the medical cart in the hallway, and returned with an additional patch. S. Staff E completed hand hygiene, donned gloves, and placed the 3rd patch per resident request. Staff assisted the resident with pulling up his LE garments. The patches were not dated. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff E demonstrated inconsistent hand hygiene practices with glove removal/application, did not utilize a gown with patch placement on the resident's buttocks, did not maintain clean and dirty environments when opening packages, placement and removal of bandages, and placement of opened bandages on incontinence pad and under her arm. On 6/25/25 at 7:50 AM the IP stated concerns with techniques during the wound care included: not dating any of the dressings, holding open bandages against the staff's body, obtaining items from the floor without changing gloves with hygiene, not maintaining clean and dirty techniques. The IP stated a gown should have been utilized with the dressing application to the buttocks. On 6/25/25 at 8:25 AM the Director of Nursing (DON) stated personal protective equipment (PPE) related to EBP should be utilized whenever staff were completing wound care to BLE's. The DON stated she did not expect the nurse to wear a gown when applying dressing(s) to the buttocks as the wounds were on the BLE's. The DON did not expect the CNAs to utilize PPE as they were not doing wound care to the resident's BLE. The DON concurred the staff should have maintained a dirty and clean environment during wound care. Reviewed the EBP signage on Resident #32's door with the DON, and the DON stated she focused on the use of PPE during wound care dressing. The U.S. Department of Health and Human Services Centers for Disease Control and Prevention EBP sign on Resident #32's door revealed providers and staff must wear gloves and gown during high contact resident care activities including dressing, bathing, transferring, hygiene, changing briefs or assisting with toileting, and wound care.