STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wabasso Restorative Care Center	660 Maple Street Wabasso, MN 56293

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 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 interview and record review the facility failed to report an injury of unknown origin within the two-hour time period for reporting for 1 of 2 residents (R2) who had an injury of unknown origin of the right tibia (shin bone) and fibula (calf bone).Findings include:Findings include:R2's face sheet dated 4/28/26, identified diagnoses of paraplegia (paralysis to lower half of body), unspecified fracture of shaft of right tibia subsequent encounter for closed fracture with routine healing, unspecified fracture of shaft of right fibula subsequent encounter for closed fracture with routine healing, reduced mobility, weakness, adult failure to thrive neuralgia (severe nerve pain) and neuritis (inflammation of nerve).R2's comprehensive Minimum Data Set (MDS) dated [DATE], identified R2 had no cognitive impairment. R2 had impairment to both sides of lower extremities, required staff assistance with dressing, turning, and transferring surfaces. R2 used a wheelchair for mobility.R2's activities of daily living (ADL) care plan dated 5/5/25, identified R2 was able to use a wheelchair independently in the facility, and transferred with total dependence of two with a mechanical lift. Bedrest with air mattress, up to chair for one hour per shift.R2's progress note dated 4/14/26 at 8:05 a.m., identified the night nurse reported that R2 had developed edema (swelling) on the right lower leg. R2 was assessed and denied hitting his leg on anything. Physician was informed of the situation and ordered ACE wraps to begin with. R2 should be observed and if the foot does not get better, get an x-ray. R2's legs were wrapped and are being observed.R2's progress note dated 4/14/26 at 10:34 p.m., identified the on-call physician was notified due to increased swelling of R2's right lower extremity. Assessment completed with +3 pitting edema, poor capillary refill noted. R2 was sent to the emergency department for further evaluation of suspected fracture.R2's Emergency Department care summary dated 4/15/26, identified R2 presented to emergency department with complaints of right lower extremity swelling and crepitus (crackling, popping or grinding sensation or sound that occurs in joints, bones, or soft tissue). Facility reported swelling started one to two days ago. No recent falls or notable injury to cause this. X-rays identified R2 had an acute oblique longitudinal fracture of the distal tibial shaft with a lateral cortical step-off measuring up to 6 millimeters (mm) (indicating a higher energy injury), he also had a mildly displaced distal fibular shaft fracture all about 10 centimeters (cm) from the ankle. It was reported that R2 accidentally hit his right lower leg in a wheelchair. R2 was splinted and discharged back to facility.R2's progress notes dated 4/15/26 at 2:17 a.m., identified R2 returned from the emergency department with a diagnosis of closed fracture of right tibia and fibula initial encounter. Physician and director of nursing (DON) notified. Will notify power of attorney (POA) in the morning.The State Agency had no incident report submitted pertaining to R2's fractures. During an interview on 4/29/26 at 12:32 p.m., director of nursing (DON) and admissions director (AD)-A present. DON stated the incident was not reported to the State Agency and that she found out that he had fractures around 8:00 a.m., on 4/15/26. AD-A stated the origin of the injury came from the wheelchair when R2 came back to the facility he told us and it was in the notes from the hospital so it didn't meet criteria to report. If the source of injury was unknown, facility would report two hours from the time it happened. DON stated before R2 went to the hospital he did (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not know how the injury occurred. When R2 returned from the hospital the paperwork stated that it was from the wheelchair. R2 had a new power wheelchair and had assessments done and passed them so he was able to use the power chair. AD-A stated R2 changed to a different story a couple days after he returned from the hospital, reporting the fracture was caused from a transfer. DON stated as soon as R2's story changed she began education with nursing staff. DON had begun watching staff complete mechanical and sit-to-stand lift transfers, it is a work in progress. DON stated she watched R2 go in and out of the smoking area door as she thought maybe the door shut to hard and got his foot but R2 went in and out without difficulty. R2 was also reassessed by therapy for the power wheelchair. AD-A stated the facility was unable to determine a root cause for the fracture because all the staff that transferred R2 on the days leading up to the incident could not recall R2 bumping his leg, the names of staff he gave worked on 4/11/26 together, only NA-D worked 4/13/26, and they could not nail down a time so it was inconclusive.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure accurate comprehensive assessments for full body mechanical lift slings according to manufacturer's guidelines to ensure safe transfers for 2 of 2 residents (R2, R4) reviewed for accidents. The manufacturer instructions for Sling Selection Guide dated 5/1/26, indicated sling selection to use with the full body lift was determined by both the resident's height and weight. The guide identified it was very important to use the correct sized sling and make sure it was fitted properly prior to lifting. Size small ranged from 75 pounds (lb.) to 150 lbs. with height from 4 feet (ft) 11 inches (in) to 5 ft 4 in, medium sized ranged from 125 lbs. to 200 lbs. with height range of 5 ft 3 in to 5 ft 8 in, large slings from 175 lbs. to 300 lbs. with height of 5 ft 7 in to 6 ft, extra-large slings were from 275 lbs. to 500 lbs. with height from 5 ft 11 in to 6 ft 4in, extra extra large slings from 350 lbs. to 600 lbs. with height determined as needed.R2's face sheet dated 4/28/26, identified diagnoses of paraplegia (paralysis to lower half of body), unspecified fracture of shaft of right tibia subsequent encounter for closed fracture with routine healing, unspecified fracture of shaft of right fibula subsequent encounter for closed fracture with routine healing, reduced mobility, weakness, and adult failure to thrive.R2's comprehensive Minimum Data Set (MDS) dated [DATE], identified R2 had no cognition issues. R2 had impairment to both sides of lower extremities, required staff assistance with dressing, turning, and transferring surfaces. R2 used a wheelchair for mobility. R2 weighed 235 pounds and was 69 inches (5 feet 7.5 inches).R2's activities of daily living (ADL) care plan dated 5/5/25, identified R2 was able to use a wheelchair independently in the facility, and transferred with total dependence of two with a Hoyer (brand of full body mechanical lift). R2's care plan did not identify what size mechanical lift sling to use during transfers.R2's care plan did not identify what size mechanical lift sling to use for transfers.R2's Lift Mobility Status-V1 dated 1/8/26, completed by a registered nurse (RN), identified R2 was not bedfast, could not stand, pivot, or walk. R2 could tolerate a semi-reclined position and R2 will continue to use full lift with two staff assist for transfers. The assessment did not identify [NAME], weight, nor the sling size R2 required for transfers. R4R4's face sheet dated 4/29/26, identified diagnoses of spondylosis (degenerative changes to spine) without myelopathy (spinal cord compression) or radiculopathy (compression of spinal nerve root) lumbar (lower spine) region, muscle weakness, unsteadiness on feet, and spinal stenosis (narrowing of spinal canal).R4's admission MDS dated [DATE], identified R4 had no cognition issues. R4 required substantial assistance to roll, sit to lying, lying to sitting, sitting to standing and was dependent on staff to transfer from surfaces. R4 weighed 220 pounds and was 71 inches (5 feet 9 inches). R4's Lift Mobility Status-V1 dated 4/12/26, completed by an RN identified R4 was not bedfast, could not stand, pivot, or walk. R4 could tolerate a semi-reclined position, weight was between 376-420 pounds (which was inconsistent with the MDS dated [DATE].) and required Hoyer (brand of mechanical lift). Further, the assessment did not identify which size sling R4 required. R4's ADL care plan dated 4/11/26, identified R4 was dependent for transfers. R4's care plan did not identify what size mechanical lift sling R4 required or what device to use for transfers.During an interview on 4/29/26 at 9:34 a.m., nursing assistant (NA)-B stated there were three different sizes for mechanical lift slings depending on how large the person was. On each lift sheet there is a label that says sizes and which one to use is based on weight. NAs choose the size based off that information; NA-B did not articulate height was also required to determine appropriate size.During an interview on 4/29/26 at 10:32 a.m., NA-C stated the nurse would determine sling size. On the sling it would say small, medium, large, or extra-large. NA's could find the information in the care plan.During an interview on 4/29/26 at 9:43 a.m., licensed practical nurse (LPN)-A stated at admission the nurse completed an assessment on resident transfers. Sling sizing goes by resident weight and therapy determines sling size. LPN-A reviewed R4's care plan and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verified the care plan did not identify mechanical lift sling size or what type of machine R4 needed to transfer. LPN-A reviewed R2's care plan and verified the care plan did not identify mechanical lift sling size. LPN-A stated the director of nursing (DON) or medical records complete the care plan, not the floor nurses. LPN-A would expect the sling sizes and what lift to use for residents would be in the care plan.During an interview on 4/29/26 at 10:03 a.m., certified occupational therapy assistant (COTA)-A stated nursing was in charge of sizing slings for residents that use mechanical lifts. Therapy did not make that determination.During an interview on 4/29/26 at 12:32 p.m., DON stated nursing assesses sling sizes for residents. The weight of the resident determines what sling size to use; DON did not articulate height was also required to determine appropriate sling size. The MDS or floor nurses would put the information in the resident care plan. DON stated it was not her expectation that mechanical lift sling sizes would be included in the care plans but that the information would be in a binder at the nurse's station. DON went to the nurses' station and took the NA binder and looked through it, there was no information about sling sizes in the NA binder. DON stated she would find an NA and ask how they know the sling sizes. DON went to NA-B who stated NA's decided sling size by looking in the storage closet by the office at the sling size guide and resident's weight.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to develop an individualized pain management plan for wound treatments and failed to provide pain management during wound treatment for 1 of 2 residents (R1) reviewed for pain management.Findings include:R1's face sheet dated 4/28/26, identified diagnoses of polyneuropathy (breakdown of nerves), fracture of unspecified part of neck of left femur (thigh bone), and polyosteoarthritis (degeneration of joints leading to pain and stiffness).R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had mild cognitive impairment. R1 had verbal behaviors directed towards others one to three days and would reject cares one to three days. R1 required supervision/touch assistance with dressing, and was independent with transferring, bed mobility, and moving surfaces. R1 was occasionally incontinent of urine and frequently incontinent of bowels. R1 was not at risk for developing pressure injuries and did not have pressure injuries.R1's care plan dated 4/22/26, identified R1 was on aspirin therapy. Interventions included to administer anticoagulation medication as ordered by physician.R1's care plan dated 4/22/26, identified R1 was on opioid pain medication related to fracture. The goal was for R1 to be free of any discomfort or adverse side effects from pain medication. Interventions included to administer analgesic medications as ordered by physician, monitor/document side effects and effectiveness every shift, for respiratory depression: monitor respiratory rate, depth, and effort after administration of pain medications, monitor for increased risk of falls, monitor/document/report as needed adverse reactions to analgesic therapy: altered mental status, anxiety, constipation, depression, dizziness, lack of appetite, nausea, vomiting, pruritis (itchy skin), respiratory distress/decreased respirations, sedation, and urinary retention. Monitor/document pain on a scale of 0 to 10 before and after implementing measures to reduce pain. R1's care plan did not address R1's acceptable level of pain. R1's care plan dated 2/12/26, identified R1 had chronic pain related to absence of toes on both feet, polyneuropathy, and gastroesophageal reflux disease. Interventions included R1's pain was aggravated by neuropathy, pain was alleviated by Tylenol, Gabapentin, and rest. Monitor/record/report to nurse R1's complaints of pain or requests for pain treatment. Notify physician if interventions are unsuccessful or if current complaint is a significant change from R1's past experience of pain.R1's care plan dated 4/7/26, identified R1 had pressure wounds. Although the care plan included the intervention to treat pain as per orders prior to treatment/turning etc to ensure comfort- there was no associated physician order that directed which analgesic should be administered or when prior to the wound treatment. R1's physician orders dated 4/29/26, included Aspirin 81 milligrams (mg) daily, Tylenol 1,000 mg every 6 hours as needed for moderate pain, Gabapentin 600 mg every 8 hours as needed for pain, Oxycodone 5 mg every 4 hours as needed for severe pain with a maximum daily does of 30 mg.R1's medication administration record (MAR) dated April 2026, identified non-pharmacological pain interventions: 1. Ice 2. Distraction 3. Rest. Effectiveness-Effective or Not Effective every day and night shift document non-pharmacological interventions tried alongside of medication for pain. Offer resident pain medications frequently. Every day and night shift.In review of R1's records there was no indication of a comprehensive assessment or treatment orders or care plan interventions that addressed R1's pain prevention during wound treatments. R1's MAR dated 4/30/26, identified Aspirin was given at 8:00 a.m. with a pain level identified at 6. The record revealed no indication non-pharmacological interventions were offered or attempted and no indication R1 was offered or administered Tylenol, Gabapentin, or Oxycodone.During an observation and interview on 4/30/26 at 11:49 a.m., licensed practical nurse (LPN)-A entered R1's room to complete a dressing change to R1's buttocks. R1 was lying on his back on the bed on top of an overlay air mattress. LPN-A opened R1's brief and noticed R1 had enlarged testicles, which LPN-A stated had not been enlarged the day before. LPN-A examined R1's testicles and asked R1 if it caused him pain. Registered nurse (RN)-A entered room and examined testicles. R1 stated it did not hurt (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when RN-A touched abdomen and testicles. R1 began to get upset and yell at LPN-A for taking so long to do the dressing change. R1 stated he was cold and hurts. LPN-A and RN-A began to roll R1 to his right side and R1 yelled that they needed to lift his leg when they rolled him. LPN-A removed the dressing on R1's bottom and began cleaning the wound. R1 continued to yell that he was in pain and made noises ooooooohhhhhhhm ahhhhhhhhh, mmmmmmmm and f*ck. R1 then screamed that it stung and that LPN-A needed to hurry up. LPN-A stated he would get R1 pain medication and R1 stated oh, I'm gonna need it.During an interview on 4/30/26 at 3:26 p.m., nursing assistant (NA)-C stated R1 screamed in pain every time he was turned or repositioned. R1 had a lot of pain and NA-C would attempt to soothe him and explain what was going to calm him. NA-C stated she would report that R1 was in pain to the nurses and trained medication aides (TMA) every time she worked with R1.During an interview on 4/30/26 at 3:31 p.m., trained medication assistant (TMA)-C stated R1 was quite stiff and would yell every time he moved positions.During an interview on 4/30/26 at 2:38 p.m., TMA-B stated she only gave as needed pain medication if a resident asked for it or the nurse told her to give it. The nurse did not have to assess the resident prior to TMA-B administering the medication but the nurse would assess for effectiveness. TMA-B was assigned to pass medications to R1 on 4/30/26. During the morning medication pass TMA-B gave R1 aspirin and rated his pain at 6. TMA-B did not notify LPN-A what R1's pain level was. R1 did not ask for pain medication and he usually would. This afternoon, R1's pain was at a 7 and LPN-A told TMA-B to give R1 Tylenol for pain. R1 asked for Gabapentin at that time also.During an interview on 4/30/26 at 2:35 p.m., LPN-A stated with a pain level of 6 you can start with the lowest Aspirin or Tylenol if R1 could have it. LPN-A stated if those interventions did not work then R1 could try Oxycodone. LPN-A stated 8 would be considered severe pain. LPN-A did not offer R1 pain medication prior to the dressing change we had started already and I should have maybe given before because R1 was in pain every time he was turned he had aspirin this morning. LPN-A stated R1 had rated his pain at 8. After the dressing change was completed LPN-A asked TMA-B to give R1 pain medication and she gave Tylenol. After reviewing R1's medication orders and the FACES pain scale, LPN-A stated R1 should have received Oxycodone for severe pain. LPN-A stated most of the time when he asked R1 about his pain he would be laying down and not in pain but when R1 moved that was when he was in pain.During an interview on 4/30/26 at 3:35 p.m., director of nursing (DON) stated R1 should have been offered pain medication when his pain was identified at 6. DON would have expected LPN-A and RN-A to stop the dressing change when R1 voiced pain. DON stated staff are to utilize non-pharmacological interventions such as putting pillows under R1's legs, calling R1's daughter, and putting Western shows on the television prior to pain medication administration. R1 had returned from the hospital on 4/29/26, and prior to the hospitalization the facility had worked with the physician on R1's pain and he had Oxycodone scheduled not just as needed. Staff should use pain scale or the FACES scale to determine level of pain. DON stated Tylenol would be an appropriate choice for pain level of 8, start with the lowest medication first and move up. DON stated R1's pain needed to be assessed and documented for the physician to review and determine if the medication should be scheduled or remain as needed. DON stated that a nurse must assess the resident prior to a TMA giving as needed medications.The facility FACES Pain Assessment Tood undated, identified the facility utilizes a numeric/faces pain assessment tool which combines a 0-10 numeric scale with corresponding facial expressions and severity categories. The scale defines 0 as no pain, 1-3 as mild, 4-6 as moderate, 7-9 as severe to very severe, and 10 as worst pain possible, and is intended to promote consistent identification and communication of pain levels.The facility 0-10 Scale of Pain Severity undated, identified severity and description of experience:0-no pain I have no pain.1-minimal my pain is hardly noticeable.2-mild I have a low level of pain. I am aware of my pain only when I pay attention to it.3-uncomfortable My pain bothers me but I can ignore it most of the time.4-moderate I am constantly aware of my pain but I can continue most activities.5-distracting I think about my pain most of the time. I cannot do some of the activities I need to do each day because of the pain.6-distressing I think about my pain all of the time. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I give up many activities because of my pain.7-unmanageable I am in pain all the time. It keeps me from doing most activities.8-intense my pain is so severe that it is hard to think of anything else. Talking and listening are difficult.9-severe my pain is all that I can think about. I can barely talk or move because of the pain.10-unable to move I am in bed and cant move due to my pain. I need someone to take me to the emergency room to get help for my pain.

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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 observation, interview, and document review the facility failed to ensure proper hand hygiene and failed to ensure clean surface are for wound supplies for 2 of 2 residents (R2, R1) reviewed for pressure ulcers.Findings include:R2's face sheet dated 4/28/26, identified diagnoses of paraplegia (paralysis to lower half of body), pressure ulcer stage 4 right buttock, pressure ulcer stage 4 left buttock, and pressure ulcer stage 4 of the sacral region.R2's comprehensive Minimum Data Set (MDS) dated [DATE], identified R2 had no cognition impairment. R2 had impairment to both sides of lower extremities, required staff assistance with dressing, turning, and transferring surfaces. R2 used a wheelchair for mobility.R2's care plan dated 11/1/25, identified R2 required enhanced barrier precautions (EBP) (use of gown and gloves during high contact interactions) related to open wounds, colostomy, and urinary catheter. Interventions included direct care staff to utilize gown and gloves for all personal care, monitor for signs/symptoms of infection. Document and properly report signs/symptoms of potential infections. Monitor psychosocial and mental well-being related to EBP. Document any changes and report any symptoms promptly.During an observation on 4/30/26 at 10:19 a.m., licensed practical nurse (LPN)-A entered R2's room wearing EBP. R2 was lying on an overlay mattress on his back in bed. LPN-A did not sanitize the work space prior to beginning wound care. LPN-A lowered R2's brief and began examining R2's penis with his gloved hands. LPN-A continued to wear the same gloves and turned around and grabbed 4 inch (in) by 4 in gauze from the gauze container. Using the same gloves, LPN-A wiped around the head of R2's penis. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A applied barrier cream to his gloved finger and wiped it around R2's penis. LPN-A removed gloves and put on a new pair without sanitizing hands. R2 rolled to his left side. LPN-A removed all three of R2's dressings. LPN-A removed gloves and applied a new pair without sanitizing his hands. LPN-A took gauze from the container, soaked it with a wound cleanser and placed the gauze inside the right pressure ulcer. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A took gauze from the container, soaked it with a wound cleanser and placed the gauze inside the left pressure ulcer. LPN-A removed more gauze from the container, soaked it, removed a glove and put a new one on without sanitizing his hands and put the gauze in the sacral ulcer. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A removed the gauze from all three wounds. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A applied wound cleanser to gauze and began wiping around right ulcer. LPN-A threw away the gauze and reached his hand into the gauze container and got more gauze. Applied wound cleanser to gauze and began wiping around left ulcer. LPN-A removed a glove, did not sanitize his hands, and applied a new glove. LPN-A grabbed more gauze from the container, soaked it in wound cleanser and wiped around the sacral and perineal region. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A opened a package of Calcium Alginate (highly absorbent material used to manage drainage and promote healing in wound care) and took a bandage scissors and cut the Calcium Alginate into three strips. LPN-A took a strip and placed it in the left ulcer. LPN-A removed gloves and applied a new pair without sanitizing hands. Took another strip and placed in the right wound. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A then took the final strip and placed it in the sacral wound. LPN-A began touching the Calcium Alginate that was in the left ulcer. LPN-A picked up a Mepilex (bordered foam dressing) and removed the sticky back piece. LPN-A then reached into the gauze container and grabbed some gauze. LPN-A wiped the gauze around the sacral and left ulcers. LPN-A applied Mepilex dressings to the ulcers. LPN-A removed gloves and adjusted R2 in bed. LPN-A took the full garbage and left room. LPN-A walked down the hallway and entered the utility room, threw garbage away and washed hands.R1R1's significant change MDS dated [DATE], identified R1 had no cognitive impairment. R1 had a stage 3 pressure ulcer.R1's care plan dated 4/7/26, identified R1 had pressure wounds. Interventions included (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	treat pain as per orders prior to treatment/turning etc. to ensure the residents comfort. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue, and exudate.During an observation on 4/30/26 at 11:49 a.m., LPN-A entered R1's room wearing EBP and brought wound supplies into room to perform a dressing change to R1's ulcer. LPN-A set the supplies on the overbed table. LPN-A removed the tabs from R1's brief and pulled the brief down. R1's testicles were enlarged and LPN-A began examining them with his gloved hands. LPN-A took some gauze from the container and wiped around R1's penis and testicles. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A lifted the wound supplies into his hand and arm, took a sanitizing wipe, wiped down the overbed table, and placed the supplies back on the table. LPN-A opened Calcium Alginate. LPN-A removed gloves and applied a new pair without sanitizing hands. Registered nurse (RN)-A entered room wearing EBP to assist with dressing change. RN-A examined R1's penis and testicles, removed gloves and applied a new pair without sanitizing hands. LPN-A and RN-A rolled R1 to his right side. R1 was incontinent of bowels. LPN-A cleaned bowels. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A removed dressing from R1's sacral ulcer. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A sprayed wound cleanser onto gauze and cleaned ulcer. LPN-A removed gloves and applied a new pair without sanitizing hands. LPN-A placed Calcium Alginate on wound bed, opened and placed Mepilex over ulcer. LPN-A removed gloves and applied a new pair without sanitizing hands. RN-A removed gloves and applied a new pair without sanitizing hands. RN-A applied cream to penis and removed gloves. LPN-A and RN-A boosted R1 in bed. LPN-A picked up wound supplies, washed overbed table, and left room.During an interview on 4/30/26 at 12:28 p.m., LPN-A stated when doing dressing changes he would sanitize his hands prior to the first glove application and when the dressing was completed. LPN-A stated he should have cleaned the work surface prior to setting wound supplies on it for R2.During an interview on 4/30/26 at 3:35 p.m., director of nursing (DON) stated hands should be sanited before and after wound care is completed. DON expected the surface that the wound supplies would be placed on should be cleaned prior to putting wound supplies on it.The facility Hand Hygiene policy undated, identified the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to putting on gloves, and immediately after removing gloves. Hand hygiene should be completed when, during resident care, moving from a contaminated body site to a clean body sit