STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265607	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowcreek Wellness & Rehabilitation	250 New Florissant Road South Florissant, MO 63031

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 - Immediate jeopardy to resident health or safety 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 interview and record review, the facility failed to ensure residents were free from neglect when staff failed to provide necessary services to avoid physical harm. On 5/26/25, Certified Nursing Assistant (CNA) D provided care to Resident #1, who had limited mobility after a stroke affecting his/her dominant side and an above the knee amputation. The resident had been assessed as needing total dependence on staff for personal hygiene and required substantial/maximal assistance to roll left to right. Resident #1 was left unattended in a raised bed when CNA D walked away to change his/her gloves. The resident fell out of the elevated bed onto the floor and was transported to the emergency room. The resident sustained a fracture to his/her right femur, a contusion to his/her shoulder, and the resident expressed feelings of being scared due to the traumatic event. The sample size was 12. The census was 108. The Administrator was notified on 6/18/25 at 5:05 P.M., of an Immediate Jeopardy (IJ) which began on 5/26/25. The IJ was removed on 6/18/25 as confirmed by surveyor onsite verification. Review of the facility's Abuse Prevention and Prohibition Program Operational Manual, Abuse and Neglect policy, revised 8/2020, showed: -Purpose: To ensure the facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements; -Policy: -Each resident has the right to be free from mistreatment, neglect, and abuse, involuntary seclusion and misappropriation of property. The facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property; -The facility is committed to protecting residents from abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors; -The Administrator is responsible for coordinating and implementing the facility's abuse prevention policies, procedures, training programs, and systems; (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	-Procedure: -Training: All employees, contractors and volunteers will be trained through orientation and ongoing training sessions, no less than annually, on the following topics: -Who is a covered individual responsible for reporting; -Abuse prevention; -Identification and recognition of signs and symptoms of abuse/neglect; -Protection of residents during an abuse investigation; -Investigation; ` -Reporting and documentation of abuse and neglect; -Reporting requirements of staff related to allegations of abuse/neglect without fear of reprisal; -Follow-up from the facility; -Prevention: -Supervisors shall immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring; -The facility maintains adequate staffing on all shifts to ensure that the needs of each resident are met; -Resident assessments and care planning are performed to monitor resident needs and address behaviors that may lead to conflict; -Identification: -The facility provides facility staff with training to enable the identification of the following signs and symptoms of potential resident abuse and neglect: -Physical Neglect: -Inadequate provision of care; -Caregiver indifference to resident's personal care and needs; -Leaving someone unattended who needs supervision. Review of the facility's Care and Services policy, revised 6/2020, showed: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Purpose: To ensure through an interdisciplinary team (IDT) process, that all residents receive the necessary care and services based on an individualized comprehensive assessment process; -Policy: -Residents are provided with the necessary care and services to maintain the highest practicable physical, mental, and social well-being in an environment that enhances quality of life in the scope of a long-term care facility. Care and services are provided in a manner that consistently enhances self-esteem ad self-worth; -Procedure: -The facility will have sufficient staff to provide services to residents with the appropriate competencies and skill sets to provide nursing and related services to ensure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being as determined by individualized resident assessments and plans of care. Review of the facility's Care Planning policy, revised 6/2020, showed: -Purpose: To ensure that a comprehensive person-centered care plan is developed for each resident based on their individualized assessed needs; -Each resident's comprehensive care plan will describe the following: -Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being; -Any services that would be required, but are not provided due to the resident's exercise of rights, which includes the right to refuse treatment; -Resident Rights-Care planning: -The resident has the right to receive the services and/or items included in the plan of care; -The interdisciplinary team will revise the Comprehensive Care Plan as need at the following intervals: -As dictated by changes in the resident's condition; -To address changes in behavior and care; and -Other times as appropriate or necessary. Review of the facility's undated Fall Management Program, showed: -Purpose: To prevent resident falls and minimize complications associated with falls through the development of a Fall Management Program; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Policy: The facility will provide the highest quality care in the safest environment for the residents residing in the facility. The facility has developed a Fall Management Program that strives to prevent resident falls through meaningful assessments, interventions, education, and reevaluation; -Procedure: -Assessment: -The licensed nurse will assess each resident for their risk of falling upon admission, quarterly, and with a significant change in condition; -Based on the information gathered from the history and assessment of the resident, the nursing staff and interdisciplinary team, with input from the attending physician, will identify and implement interventions to reduce the risk of falls; -Care Planning: -The nursing staff will develop a plan of care specific to the resident's care needs with interventions to reduce the risk of falls; -The interdisciplinary team will routinely review the plan of care at a minimum of quarterly, with a significant change in condition, and post fall. Interventions will be implemented or changed based on the resident's condition and response; -Functional Mobility: -Reassess patient's mobility status daily; -Determine the safest use of side rails; -Post-Fall: -Following a resident's fall, the licensed nurse will complete an incident report and a post-fall assessment and investigation within 24 hours or as soon as practicable; -The licensed nurse will review the circumstances of the fall, review the plan of care, implement new interventions as appropriate, and revise the plan as indicated; -The Interdisciplinary Team Committee will meet within 72 hours of a fall. The IDT Committee will review and document: -Summary of events following a fall; -Root cause analysis; -Referrals, as necessary; and -Interventions to prevent future falls; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Documentation: -The Interdisciplinary Team Committee will document findings and recommendations in the resident's medical record; -Nursing staff will document the resident's response to interventions being utilized in the resident's medical record; -The resident's care plan will be updated as necessary; -Education: -Staff are in-serviced to the Fall Management Program at a minimum annually as well as immediately after any changes/up-dates to this program; -Interim in-services is provided, as needed, based on frequency and severity of falls; -In-service records are maintained to document that all staff attends in-service on all aspects of the fall program at least annually. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/1/25, showed: -Cognitively intact; -Used a wheelchair; -Roll left to right - substantial/maximal assistance; -Impairment on one side -upper extremity; -Impairment on both sides - lower extremity; -Toileting hygiene/Shower/bathe - dependent; -Diagnoses included depression, heart failure, diabetes, and non-Alzheimer's dementia. Review of the resident's medical record, showed diagnoses included muscle wasting and atrophy (the thinning or loss of muscle tissue) to the right and left shoulders, hemiplegia (inability to move on one side of the body) and hemiparesis (weakness on one side of the body) following a stroke affecting the right dominate side, disorder of bone density and structure, muscle weakness, dementia, and Alzheimer's disease. Review of the resident's care plan, showed: -Focus initiated 8/22/24: The resident has an activity of daily living (ADL) self-care performance deficit related to right side hemiplegia; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Goal: Maintain current level of ADL function; -Interventions/Tasks: -Initiated on 8/22/24, personal hygiene/oral care: The resident is totally dependent on staff for personal hygiene and oral care; -Initiated on 5/2/25, roll left to right: Substantial/maximal assistance. Review of the resident's progress notes, showed: -5/26/25 at 8:53 A.M.: at 6:15 A.M., CNA reported resident rolled off bed. Staff entered the room and noted the resident lying on the floor on the right side of the bed. Resident positioned halfway on the left side and back. Resident stated he/she slid off the bed and landed on the left shoulder and hit his/her head. Resident complained of pain moving his/her upper arms, left leg, and right thigh. Pain is causing limited range of motion to all extremities. Obtain vital signs: Blood pressure 168/96 (normal 90/60 through 120/80), temperature 97.8 (normal 97.8 through 99.1), heart rate 88 (normal 60 through 100), respirations 16 (normal 12 through 18). Notified 911, resident sent to the hospital. Notified the physician. New orders for x-ray and keep bed in low position; -5/26/25 at 3:53 P.M., resident returned from the hospital at 2:00 P.M., resident diagnosed with closed fracture of the neck of the right femur and contusion to the left shoulder. Physician notified; new orders received. Review of the resident's hospital records, for date of service 5/26/25, showed: -Chief complaint: Patient presents with fall: 9:34 A.M., patient with a history of right above the knee amputation, presenting to the emergency department via emergency medical services (EMS) complaining of pain all over after apparently falling out of bed at the nursing home earlier this morning. Apparently, nursing home staff found him/her on the floor just after 6:00 A.M. this morning. They assisted him/her back to bed without event, but he/she apparently began to complain of pain all over. He/She recalls rolling out of bed. He/She states he/she landed on his/her left shoulder and right thigh. He/She notes that he/she has phantom limb pain (pain felt in extremities that have been amputated) in the right lower extremity. He/She relates a mild headache and neck stiffness. He/She denies any chest pain, rib pain, abdominal pain, or back pain. He/She denies any nausea, vomiting, visual changes, or acute neurologic changes. He/She states he/she is never ambulatory and does not use a prosthetic right leg; -Musculoskeletal: Positive for arthralgias (pain in one or more joints), myalgias (muscle pain), and neck stiffness; -Neurological: Positive for headaches; -Closed fracture of neck of right femur; -Contusion of left shoulder. Review of the resident's Trauma Screen, effective 5/27/25 at 11:13 A.M., showed: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Has the event caused you to feel very scared, helpless, or horrified - Yes; -Has the event caused you to be constantly on guard, watchful, or easily startled - Yes; -Have you tried hard not to think about the event or went out of your way to avoid situations that remind you of it - Yes; -Summary of care provided: He/She has not had any past trauma in his/her life, but this fall has scared him/her, and he/she tries not to think about it, and he/she hopes it does not ever happen again. Review of the resident's progress notes, showed on 5/27/25 at 11:28 A.M., social worker met with the resident to do a trauma screen with him/her. The resident explained that he/she had not had any trauma before in his/her life, but because of his/her fall, he/she was scared because this had never happened before. Review of the facility's Initial Reporting form, dated 5/26/25, showed: -Alleged Victim - Resident #1; -Steps taken to protect resident: Assessment was conducted and was noted to have pain on exam that limited mobility in the affected left (L) shoulder and right (R) leg. Vitals obtained and resident was placed in bed in low position until the ambulance could arrive; -Witness - Blank; -Report Submission: Interim Director of Nursing (DON) on 5/26/25 at 1:15 P.M.; -No facility investigation, summary, witness statements, and/or findings provided at the time of the investigation. Review of CNA D's Correction Action Memo, showed: -Dated 5/26/25; -Type of violation: -Violation of policy or procedure; -Carelessness; -Employer Statement: -You were doing rounds and providing cares when it was reported that a resident fell out of the bed. Also, during this shift there has been an allegation of drug and alcohol abuse while working. Spoke with CNA D at 1:40 P.M. and he/she was suspended, pending investigation; -Action Being Taken: Suspension; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Employee Statement: He/She stated that he/she was providing cares and he/she got bowel movement on his/her gloves. He/She then went to change them and that is when the resident rolled out the bed; -Employee signature - Verbal by phone on 5/26/25 at 1:40 P.M.; -Supervisor signature - dated 5/26/25; -Witness signature - blank; -Dated 5/29/25; -Type of violation: -Violation of safety rules; -Unsatisfactory performance; -Carelessness; -Employer Statement: You were assisting a resident with cares, alone, and when you turned and changed gloves, the resident fell out of bed onto the floor and a fracture was indicated on his/her scans; -Action Being Taken: Termination; -Objective/Solution: This resident needed 2-person assist for transfers/bed mobility/and ADLs. There was no assist bar to help with rolling and due to stepping away, CNA D left the bed up and the resident rolled out and an injury occurred. This would have been prevented if CNA D were using 2 staff; -Supervisor signature dated 5/29/25. During an interview on 6/17/25 at 12:11 P.M., Licensed Practical Nurse (LPN) I said he/she knew the resident. The resident had passed away. The resident had a femur (upper leg bone) fracture. The fall happened on the night shift. The resident was being changed and somehow rolled out of bed. He/She did not know the name of the staff who had provided the care but knew him/her by face. The staff was a night shift aide. LPN I said he/she was just coming into work. In shift report, he/she was told the resident had been assessed and sent to the hospital. The resident was total care. The resident needed help in bed sometimes, but could move himself/herself around in bed. The resident's bedrails were to be up all the time, except when he/she was receiving care. The bedrails were for reposition assistance. The resident was an amputee. He/She was not sure if the resident could stop a fall. He/She expected staff to use two people if the resident was supposed to have that and it was never ok to turn their back to or walk away from a resident when the bed was in a high position. During an interview on 6/17/25 at 1:19 P.M., Certified Medication Technician G said it took two people to assist the resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/17/25 at 1:23 P.M., CNA H said he/she knew the resident. He/She found out the resident had fallen out of bed on Memorial Day. He/She did not talk with the resident about the fall and didn't know how the resident had fallen out of bed. When he/she came back to work, the resident was gone. CNA H said it took two people to transfer the resident. It took one person to provide care and to reposition him/her. During an interview on 6/17/25 at 1:27 P.M., LPN I said the number of staff to provide care for the resident depended upon whether or not he/she had just come from dialysis. Sometimes the resident was weak. It would take two people then but regularly, only one or two staff. He/She expected the staff to follow the resident's care plan. During an interview on 6/17/25 at 3:48 P.M., CNA C said he/she was familiar with the resident. He/She worked the night the resident fell out of bed. CNA D was assigned to the resident. He/She went to the resident's room to ask for CNA D's assistance with his/her resident and walked away back to his/her resident's room. A few minutes later, CNA D came to the door and said the resident is on the floor. The resident's bed was not against the wall, it was positioned in the room, so the floor was on both sides of the bed. The resident was a 1-person assist and fairly easy to roll. CNA C said when he/she got to the room, the resident was on his/her right side on the floor. The rails were not up on the bed on either side. The resident fell away from the side CNA D was on. He/She said CNA D said he/she went to change his/her gloves and that is how the resident fell. The bed was high when he/she went to ask CNA D for help. The resident just wanted them to get him/her up off the floor. The day the resident fell, he/she smelled alcohol on CNA D's breath when they were face to face, rolling a different resident in bed. CNA C reported this to the ADON (Assistant Director of Nursing). CNA D had come back from break smelling like weed and alcohol. He/She reported it to his/her supervisor (ADON). He/She called the ADON in the A.M. and told her CNA D couldn't work that hall. He/She said CNA D was lit and couldn't do anything. During an interview on 6/17/25 at 4:32 P.M., the Regional Nurse Consultant (RNC) said CNA D was no longer an employee after the resident's fall. Based on the investigation, CNA D did not have a 2nd person to assist with the resident's care. CNA D did not follow the resident's care plan. CNA D had been educated before. The resident was in bed and was non-weight bearing which is why he/she needed 2-people for care. The RNC said no one ever reported to her that CNA D smelled like alcohol or marijuana. She expected staff to follow the resident's care plan. During an interview on 6/18/25 at 6:46 P.M., the Interim DON said by the time the fall had been reported to her, CNA D was gone. She said it was reported to her in the past that CNA D had used alcohol/drugs while at work, but she did not have enough information to substantiate the allegations. She saw CNA D a few times, but did not smell drugs or alcohol on him/her. During an interview on 6/20/25 at 9:20 A.M., LPN F said Resident #1 told him/her the he/she bumped his/her head and he/she hit the floor hard. When he/she (LPN F) came back to work, after the fall, the resident was put on a pain management program because of the fall. LPN F said CNA D would be off the floor for long periods of time and take extended breaks. He/She said CNA D would not come back sometimes until it was time to provide care to the residents at the end of the shift. During an interview on 6/20/25 at 9:48 A.M., LPN A said he/she had worked with the resident before. He/She changed the resident alone on 6/1/25, after the resident had the fall, because they were short staffed with only one CNA and himself/herself. He/She knew the resident was 2-person assist. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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 interview and record review, the facility failed to follow their policy when a resident experienced a change in condition. Resident #1 fell out of an elevated bed onto the floor and was transported to the emergency room on 5/26/25. The resident sustained a fracture to his/her right femur (thighbone), and a contusion to his/her shoulder, The resident was readmitted to the facility on [DATE], with discharge instructions identifying symptoms to monitor for that may require the resident to return to the hospital. Facility staff documented a change in condition consistent with the hospital discharge instructions, including vomiting and lethargy, beginning on 5/29/25. On 5/30/25, the resident's oxygen saturation and respiratory rate were low and the physician was notified with orders obtained for oxygen. The facility did not document notifying the physician of the resident's vomiting, lethargy, sweating, increased blood pressure, and elevated blood sugar. The resident continued to decline, eating less, increased lethargy and sleeping, pocketing food, unable to open eyes and inability to take oral pain medications. When the resident became unresponsive on 6/2/25, staff contacted emergency services and sent the resident to the hospital. The resident expired shortly after arriving to the hospital. In addition, the facility failed to ensure physician orders for wound care were followed for one out of three sampled residents (Resident #5). Resident #5's wound treatment was not completed for two days. The census 108. The Administrator was notified on 6/18/25 at 5:05 P.M., of an Immediate Jeopardy (IJ) which began on 5/29/25. The IJ was removed on 6/18/25 as confirmed by surveyor onsite verification. 1. Review of the facility's Change of Condition Notification policy, revised 6/2020, showed: -Purpose: To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner; -Definition: -An acute change of condition (ACOC) is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains; -Clinically important means a deviation that, without intervention, may result in complications or death; -Members of the interdisciplinary Team (IDT) are expected to report and document signs and symptoms that might represent and ACOC; -The facility will promptly inform the resident, consult with the resident's attending physician, and notify the resident's legal representative when the resident endures a significant change in their condition caused by, but not limited to: -An injury/accident; -A significant change in the resident's physical, cognitive, behavioral or functional status; -A significant change in treatment; and/or (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowcreek Wellness & Rehabilitation	250 New Florissant Road South Florissant, MO 63031

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-A decision to transfer or discharge the resident from the facility; -The licensed nurse will notify the resident's attending physician when there is an: -Incident/accident involving the resident; -An accident involving the resident which results injury and has the potential for requiring physician intervention; -A significant change in the resident's physical, mental or psychosocial status, e.g., deterioration in health, mental or psychosocial status, life-threatening conditions or clinical complications; -A need to alter treatment significantly -A decision to transfer or discharge the resident from the facility; -The licensed nurse will assess the resident's change of condition and document the observations and symptoms; -Notifying the Attending Physician: -The attending physician will be notified timely with a resident's change in condition; -Notification to the attending physician will include a summary of the condition change and an assessment of the resident's vital signs and system review focusing on the condition and/or signs and symptoms for which the notification is required; -Emergency Situations: -If the resident deteriorates, the symptoms are serious, and the most rapid intervention available by a physician would place the resident in great jeopardy, call 911 for transport to hospital; -Notify the nursing supervisor of emergency situation; -A licensed nurse will document the following: -Date, time, and pertinent details of the incident and the subsequent assessment in the nursing notes; -The time the attending physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received; -Update the care plan to reflect the resident's current status; -The incident and brief details in the 24-hour report; -Complete an incident report per facility policy; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-A licensed nurse will communicate any changes in required interventions to the IDT members involved in the resident's care; -A licensed nurse will document each shift for at least seventy-two (72) hours; -Documentation pertaining to a change in the resident's condition will be maintained in the resident's medical record and on the 24-hour report. Review of the facility's Neurological Assessment policy, revised 2/2019, showed: -Purpose: To provide guidelines for the performance of a neurological assessment on residents; -Nursing staff will perform a neurological assessment in the following circumstances: -Upon attending physician order; -Following a fall or other accident/injury involving head trauma; or -When indicated by resident's condition; -The following information will be documented in the resident's medical record: -The date and time the procedure was performed; -All the assessment data obtained during the procedure, including: -Eye opening; -Verbal response; -Motor response; -Pupillary response; -Limb response; -If the resident refused the procedure, the reason(s) why and the intervention taken; -The signature and title of the person recording the data; -Notify the attending physician of any change in a resident's neurological status. Early signs of neurologic compromise include changes it the resident's level of consciousness and pupillary activity; -Report other information in accordance with facility policy and professional standards of practice. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/1/25, showed: -Cognitively intact; -Used a wheelchair; -Roll left to right - substantial/maximal assistance; -Impairment on one side -upper extremity; -Impairment on both sides - lower extremity; -Toileting hygiene/shower/bathe - dependent; -Diagnoses included depression, heart failure, diabetes, and non-Alzheimer's dementia. Review of the resident's medical record, showed diagnoses included muscle wasting and atrophy (the thinning or loss of muscle tissue) to the right and left shoulders, hemiplegia (inability to move on one side of the body) and hemiparesis (weakness on one side of the body) following a stroke affecting the right dominate side, disorder of bone density and structure, muscle weakness, dementia, and Alzheimer's disease. Review of the resident's care plan, showed: -Focus: The resident has a history of stroke with right sided hemiplegia: -Goal: Be free from further complication from stroke through review; -Interventions included: Monitor level of consciousness, visual function changes, inability to communicate, aphasia (difficulty communicating), dizziness, weakness, and restlessness; -Focus: Impaired cognitive function related to unspecified dementia: -Goal: Maintain current level of cognitive function; -Interventions included: Monitor/document/report to the physician any changes in cognitive function, specifically changes in: Decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status. Review of the resident's progress notes, showed: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-5/26/25 at 8:53 A.M., at 6:15 A.M., the certified nursing assistant (CNA) reported the resident rolled off bed. Staff entered the room, noted the resident lying on the floor on the right side of the bed. Resident positioned halfway on his/her left side and back. Resident stated he/she slid off the bed and landed on the left shoulder, and hit his/her head. Resident complained of pain moving his/her upper arms, left leg, and right thigh. Pain is causing limited range of motion to all extremities. Obtained vital signs: Blood pressure 168/96 (normal 90/60 through 120/80), temperature 97.8 (normal 97.8 through 99.1), heart rate 88 (normal 60 through 100), respirations 16 (normal 12 through 18). Notified 911, resident sent to the hospital. Notified the physician. New orders for x-ray and keep bed in low position. Review of the resident's emergency room paperwork, dated 5/26/25 at 9:34 A.M., showed: -Chief Complaint: Patient presents with a fall; -At 9:34 A.M., patient with a history of high blood pressure, diabetes, stroke, congestive heart failure (CHF), dementia, and right above-the-knee amputation, presenting to the emergency department (ED) via emergency medical services (EMS) complaining of pain all over after apparently falling out of bed at the nursing home earlier this morning. Apparently, nursing home staff found him/her on the floor just after 6:00 A. M. this morning. They assisted him/her back into bed without event, but he/she apparently began to complain of pain all over. He/She recalls rolling out of bed. He/She states he/she landed on his/her left shoulder. When asked to describe these specific areas where he/she hurts the most, he/she states it is his/her left shoulder and right thigh. He/She notes that he/she has phantom limb pain (pain occurring in extremities that have been amputated) in the right lower extremity. He/She relates a mild headache and neck stiffness; -Review of systems: Neurological: Positive for headaches; -Comment: Patient who rolled out of bed at the nursing home, complaining of headache, neck pain, left shoulder pain, and right thigh pain. Review of the resident's hospital After Visit Summary, dated 5/26/25 printed 12:59 P.M., showed: -Call 911 if any of these happen: -Confused or difficulty arousing; -Fainting or loss of consciousness; -Rapid or very slow heart rate; -Difficulty with speech or vision, weakness of an arm or leg; -When to seek medical advice: Call your healthcare provider right away if any of these happen: -Another unexplained fall; -Severe headache; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Nausea and vomiting. Review of the resident's progress notes, showed: -5/26/25 at 3:53 P.M., the resident returned from hospital at 2:00 P.M. Resident diagnosed with closed fracture of neck of the right femur and contusion to left shoulder. Physician notified, new orders received. No new concerns noted. Resident is resting in bed, morphine (narcotic pain medication) intramuscular (injected into the muscle) 4 milligram (mg) given at the hospital prior to return. Pain is rating of 7 on a scale of 0 to 10 (0 indicates no pain, 10 indicates the worse pain imaginable), stated he/she wants to sleep. Vitals blood pressure 117/71, heart rate 108, temperature 98.4, respirations 18, oxygen saturation (percentage of oxygen in the blood) 96% (normal 95% through 100%). Review of the resident's physician orders showed: -An order dated 5/26/25, low bed at all times; -An order dated 5/27/25, chart status post fall with injury every shift in progress notes; -An order dated 5/30/25, oxygen 2 liters as needed. Review of the resident's progress notes, showed: -5/27/25 at 11:28 A.M., Social Worker met with the resident to do a trauma screen. Resident explained that he/she has not had any trauma before in life, but because of his/her fall, is scared because this had never happened before; -5/27/25 at 2:14 P.M., incentive spirometry (device used for deep breathing exercises) daily/as needed (PRN) for 5 breaths. Resident will place the mouthpiece in mouth, sealing lips around it. Instruct the resident to breathe in slowly and deeply as possible, holding breath for 3-5 seconds. Exhale and rest between breaths, cough as necessary. Nurse to evaluate lungs sounds before and after use of the Incentive Spirometer, document achieved volume, heart rate, respirations, oxygen saturations and treatment time. Rinse the mouthpiece after each use. Every dayshift for shortness of breath related to chronic obstructive pulmonary disease (COPD, lung disease): Resident did not feel up to it; -5/29/25 at 2:21 P.M., nurse called to the resident's room. Resident had emesis (vomited) twice. Resident is alert, but is also lethargic (a state of extreme tiredness, sluggishness, and lack of energy), unable to swallow anti-emetic (medication or treatment that prevents or relieves nausea and vomiting) at this time. Denies any pain or discomfort at this time. Pain meds being held due to lethargy. Swelling to right hip and left shoulder. Is currently resting in bed, call light in reach. Will continue to monitor vital signs: blood pressure 110/75, heart rate 77, respirations 17, temperature 97.5, oxygen saturation 92%; -5/29/25 at 11:11 P.M., no nausea or vomiting this shift. Resident ate less than 25 percent for dinner, drank half a nepro shake (health shake for individuals with kidney failure). Denies any pain or discomfort at this time. Resident slept majority of this shift, currently resting in bed with call light in reach. Vital signs: blood pressure 103/76, heart rate 97, temperature 98.4, respirations 17, oxygen saturation 92%; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-5/30/25 at 6:30 A.M., resident sensitive to touch, unable to tolerate vital signs check, yelling don't touch me, stop. Resident noted sweaty this morning, gown damp. Blood pressure 156/77 in left leg compared to reading in upper left arm/wrist blood pressure of 89/56, pulse 81, respiration 14, temperature 98.3, oxygen saturation 88%, blood sugar 214 (normal less than 140). Notified physician. Gave orders for oxygen 2 liters as needed and to monitor; -5/31/25 at 1:05 P.M., no nausea or vomiting this shift. Resident ate less than 25 percent for both meals. Denies any pain or discomfort at this time. Resident slept majority of this shift. Currently resting. No concerns noted at this time, will continue to monitor for any acute change in condition; -6/1/25 at 3:19 P.M., resident slept most of day shift. Noted to be pocketing food (holding food in the mouth and not swallowing). Given puree for lunch. Ate less than 25 percent. Resident is resting in bed at this time, call light in reach. Will continue to monitor; -6/2/25 at 5:51 A.M., resident continues on observation related to fall with injuries to neck of the right femur and contusion to left shoulder. Resident moaned like he/she was in pain when being repositioned and changed. This nurse attempted to give resident as needed pain medication, but resident would not open his/her eyes. Resident is sleeping deeply but does respond to pain stimulus when being moved. Resident in bed with bed in low position and call light within reach; -6/2/25 at 8:20 A.M., during medication administration, notified by Certified Medication Technician (CMT) that resident blood pressure was low, and pulse elevated. Upon assessment, resident noted to have labored breathing. Eyes glossy and non-reactant to light. Unable to obtain oxygen saturation. Head of bed elevated, and oxygen therapy applied. Resident had become non-responsive to verbal commands. But responded to physical touch. Call place to 911. Resident transferred to the hospital via EMS. Management and medical doctor made aware. Message left for responsible party and first emergency contact. Awaiting call back at this time; -6/2/25 at 9:09 A.M., responsible party states he/she received call from hospital stating resident had expired. Management and medical doctor made aware. Review of the resident's vital sign log in the medical record, showed: -6/2/25 at 2:10 A.M., blood pressure 141/63, lying/left arm; -6/2/25 at 8 A.M., blood pressure 95/41, lying/left arm; -No documentation related to history of low blood pressure found. During an interview on 6/17/25 at 3:34 P.M., CNA C said he/she saw the decline in the resident in just a couple of days. The resident could not sit in his/her wheelchair. Over the days after the accident, the resident would not eat. He/She tried to feed the resident, but the resident said he/she could not eat. The resident was barely eating after the fall. After the fall, the resident would not hardly open his/her eyes. He/She noticed the resident would not stay awake. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/18/25 at 2:23 P.M., Licensed Practical Nurse (LPN) B said he/she called the doctor to get medication and intramuscular (IM) injection because the resident vomited. He/She was not able to get the IM injection from the medication dispensing machine. He/She was alerted about the vomiting and decline on 5/29/25. He/She had contacted the doctor that day and should have documented in the resident's chart. They doctor did not order to send the resident out. LPN B said he/she was not aware of the information on the resident's after visit fall hospital discharge paperwork indicating reasons for sending the resident back to the hospital. Nursing was supposed to look at that paperwork. If he/she had seen the after visit summary paperwork, he/she would have made a note in the resident's record. Looking back now, he/she would have sent the resident out. During an interview on 6/20/25 at 9:20 A.M., LPN F said he/she did not see the resident's after visit hospital summary. He/She got updated reports from each shift when he/she came in. The resident told him/her that he/she bumped his/her head. The resident told LPN F he/she hit the floor hard. When he/she came back to work, the resident was put on pain management. The medication was strong and the resident was not used to all that medication. He/She would have sent the resident out when he/she vomited. During an interview on 6/20/25 at 9:48 A.M., LPN A said he/she did not know there had been a change in the resident. The resident was sleeping a lot, but he/she did not know if this was a change in his/her behavior. The resident's vital signs were fine, so he/she did not think there was a change. LPN A said the resident would not wake up to take his/her medicine. The resident would wake up a little before, but now the resident would not open his/her mouth up all the way. He/She did not feel safe giving the resident his/her medication, so it was held. LPN A said he/she got updates at shift change, but did not know anything about the resident vomiting or being lethargic. He/She looked over the resident's progress notes and said the facility should have sent the resident out because, looking back, moaning and not opening his/her eyes was a change in the resident's condition. During an interview on 6/20/25 at 10:47 A.M., LPN J said he/she was one of the nurses who reviewed hospital discharge paperwork for the facility. Nursing staff are to review the 24-hour report. All nurses have access to the 24-hour report. The 24-hour nursing report would have given indication of the resident's decline over time. During an interview on 6/20/25 at 10:51 A.M., LPN M said they are to report to the supervisor any change in condition. During an interview on 6/20/25 at 11:40 A.M., the Assistant Director of Nursing (ADON) said the resident should have been sent to the hospital after the change of condition. The ADON said the medical doctor was adamant about not sending the resident out, so the nurse did not send him/her out. The resident should have been sent out when he/she had emesis and was lethargic, but the medical doctor said not to. She expected all nurses to review the 24-hour nursing report and compare with the observations made. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #5's quarterly MDS, dated [DATE], showed: -Cognitively intact; -No upper body impairment; -Lower body impairment: 1 side; -Dependent (Helper does all effort. Resident does none of the effort to complete activity): Toileting, lower body dressing, and personal hygiene; -Total number venous and arterial ulcers: 1; -Treatments: Pressure reducing device bed, application nonsurgical dressing; -Diagnoses included heart failure, peripheral vascular disease (PVD, poor circulation), end stage renal disease (ESRD), malnutrition, and quadriplegia (paralysis of all four limbs). Review of the resident's care plan, revised 9/10/24, showed: -Focus: Resident has a venous ulcer of the right lower calf related to congestive heart failure, PVD; -Goal: Resident's ulcer will be healed by the review date. Resident will have no signs/symptoms of infection through the review date; -Interventions: Document location of wound, amount of drainage, peri-wound area, pain, edema (swelling), and circumference measurements per facility protocol. Evaluate wound. Document progress in wound healing on an ongoing basis. Notify physician as indicated. Minimize exposure of skin to moisture from incontinence, wound drainage, or perspiration. Review of the resident's electronic Physician Order Sheet (ePOS), showed: -An order, dated 1/27/25-5/30/25, cleanse right lateral (side) lower leg with hypochlorous (wound cleanser that increases oxygenation of the wound site to improve healing). Apply calcium alginate (highly absorbent dressing) with silver, xeroform (non-adherent dressing) to wound bed. Cover with super absorbent dressing, kerlix (gauze wrap) and with ACE wrap. Daily and as needed (PRN) every dayshift for wound care; -An order, dated 5/30/25-6/4/25, cleanse right lateral lower leg with hypochlorous. Apply calcium alginate with silver, Gentamicin Ointment to wound bed. Cover with super absorbent dressing, kerlix and with ACE wrap. Daily and PRN every dayshift for wound care; -An order, dated 6/4/25, cleanse right lateral lower leg with hypochlorous. Apply calcium alginate with silver to wound bed. Cover with super absorbent dressing, kerlix and with ACE wrap. Daily and PRN every dayshift for wound care. (continued on next page)

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	265607	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowcreek Wellness & Rehabilitation	250 New Florissant Road South Florissant, MO 63031

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's May 2025 TAR, showed the ordered treatment not marked as completed on 5/4/25, 5/8/25, 5/11/25, 5/16/25, 5/18/25, 5/21/25, 5/24/25, 5/25/25, and 5/26/25; Review of the resident's June 2025 TAR, reviewed on 6/18/25, showed the ordered treatment not marked as completed on 6/13/25, 6/15/25, and 6/16/25. Review of the facility's wound report, showed the following for the resident: -4/30/25 Wound location: Right Posterior Leg; Venous Insufficiency Ulcer; -Length: 7 cm, 2.5 width, depth 0.3 cm; -Wound status: subsequent-Stable; -Dressing change: Daily. Clean with normal saline. Xeroform, calcium alginate. Absorptive dressing, dry dressing; -5/7/25 Wound location: Right Posterior Leg; Venous Insufficiency Ulcer; -Length: 7 cm, 2.5 width, depth 0.3 cm; -Wound status: subsequent-Stable; -Dressing change: Daily. Clean with normal saline. Xeroform, calcium alginate. Absorptive dressing, dry dressing; -5/14/25 Wound location: Right Posterior Leg; Venous Insufficiency Ulcer; -Length: 6.8 cm, 3 width, depth 0.3 cm; -Wound status: subsequent-Stable; -Dressing change: Daily clean with normal saline. Xeroform, calcium alginate. Absorptive dressing, dry dressing; -5/21/25 Wound location: Right Posterior Leg; Venous Insufficiency Ulcer; -Length: 7.3 cm,3.5 width, depth 0.3 cm; -Wound status: subsequent-Worsening; -Dressing change: Daily clean with normal saline. Xeroform, calcium alginate. Absorptive dressing, dry dressing; -5/28/25 Wound location: Right Posterior Leg; Venous Insufficiency Ulcer; -Length: 8 cm,3.5 width, depth 0.3 cm; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Wound status: subsequent-Worsening; -Dressing change: Daily clean with normal saline, calcium alginate. Gentamicin (antibiotic) ointment. Absorptive dressing, dry dressing; -6/4/25 Wound location: Right Posterior Leg; Venous Insufficiency Ulcer; -Length: 7.5 cm, 4 width, depth 0.3 cm; -Wound status: subsequent-stable; -Dressing change: Daily clean with normal saline, calcium alginate. Absorptive dressing, dry dressing; -6/11/25 Wound location: Right Post

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow acceptable standards of practice for infection control for three of three residents observed during wound care. Staff failed to change their gloves or sanitize their hands prior to entering the room, prior to exiting the room, and in-between removing soiled dressings, cleaning the wound, and applying new wound dressings. The staff also failed to use Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) as recommended by the Centers for Disease Control and Prevention (CDC) and required by the Centers for Medicare and Medicaid Services (CMS) for residents with wounds requiring treatment, for three residents (Residents #5, #8, and #9). The sample size was 12. The census was 108. Review of the facility's Hand Hygiene Policy, revised 6/2020, showed: -Purpose: To ensure all individuals use appropriate hand hygiene while at the facility; -Policy: The facility considers hand hygiene the primary means to prevent the spread of infection; -Facility staff are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections; -Facility staff follow the hand hygiene procedures to help prevent the spread of infections to other staff, residents, and visitors; -Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policy; -Facility staff and volunteers must perform hand hygiene procedures in the following circumstances including but not limited to: -Wash hands with soap and water: -When soiled with visible dirt or debris; -After removing personal protective equipment (PPE) and before moving to another resident in the same room or exiting the room; -Alcohol-based hand hygiene products can and should be used to decontaminate hands: -Immediately upon entering a resident occupied area regardless of glove use; -Immediately upon exiting a resident occupied area regardless of glove use; -Before moving from one resident to another in a multiple-bed room or procedure area regardless of glove use; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hand hygiene is always the final step after removing and disposing of personal protective equipment; -The use of gloves does not replace hand hygiene procedures. Review of the facility's Standard and Enhanced Precautions policy, implemented April 2024, showed: -Policy: The Facility will utilize current guidance from the CDC and the CMS to determine the appropriate PPE to be utilized during the care of residents to minimize the risk of infection or spread of infection; -Standard Precautions: -Hand Hygiene: Hand hygiene refers to hand washing with soap (anti-microbial or non- antimicrobial) OR using alcohol-based hand rubs (gels, foams, rinses) that do not require access to water. -Gloves: Gloves (clean, non-sterile) are worn when direct contact with blood, body fluids mucous membranes, non-intact skin, and other potentially infected material is anticipated; -Gowns: A gown is worn to protect skin and prevent soiling of clothing during procedures and resident care activities that are likely to generate splashes or sprays of blood body fluids, secretions, or excretions or cause soiling of clothing; -Enhanced Barrier Precautions: -For residents whom EBP are indicated, EBP should be used when performing the following high-contact resident care activities: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, and wound care; -EBP are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at high-risk. 1. Review of Resident #5's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/13/25, showed: -Cognitively intact; -Diagnoses included heart failure, malnutrition, and quadriplegia (paralysis of all four limbs). Review of the resident's care plan, dated 5/20/25, showed: -Focus: EBP related to wound; -Goal: Reduce transmission of pathogens; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Interventions: Staff members will wear clean gown and gloves while performing high contact resident care activities to include dressing, bathing/showering, providing hygiene, changing linens, changing briefs or toileting assistance. Review of the resident's electronic Physician Order Sheet (ePOS) showed an order, dated 6/4/25, cleanse right lateral (outer) lower leg with hypochlorous (wound cleansing solution). Apply calcium alginate (absorbent dressing) with silver to wound bed. Cover with super absorbent dressing, kerlix (gauze wrap) and with ACE wrap. Daily and as needed (PRN) every dayshift for wound care. Observation on 6/17/25 at 930 A.M., showed Licensed Practical Nurse (LPN) L stood at the nursing cart in front of the resident's room. He/She prepared the wound care supplies at the cart, applied gloves, and entered the resident's room. LPN L did not perform hand hygiene prior to applying gloves and did not put on a gown. LPN L pulled down the resident's right sock. The resident's leg was swollen around the wrap. LPN L removed the soiled dressing. While removing the dressing, a large piece of the resident's skin tissue came off with the dressing. The resident said Ouch. LPN L cleansed the area and applied a new dressing without changing his/her gloves or performing hand hygiene. LPN L secured the area with kerlix wrap. He/She cleaned up the supplies, removed gloves, and exited the resident's room without performing hand hygiene. 2. Review of Resident #8's quarterly MDS, dated [DATE], showed: -Severe cognitive impairment; -No upper or lower body impairment; -Dependent (Helper does all effort. Resident does none of the effort to complete activity) for toileting, upper and lower body dressing, and personal hygiene; -Diagnoses included cancer, high blood pressure, stroke, and malnutrition. Review of the resident's care plan, revised 6/2/25, showed: -Focus: EBP related to wound; -Goal: Reduce transmission of pathogens; -Interventions: Staff members will wear clean gown and gloves while performing high contact resident care activities to include dressing, bathing/showering, providing hygiene, changing linens, changing briefs or toileting assistance. Review of the resident's, ePOS, showed an order, dated 5/14/25, cleanse left side of foot. Dry and apply xeroform (non-adherent dressing) and dry dressing. Every day shift every 3 days for wound management. Review of the facility's wound report, dated 6/11/25, showed the following for the resident: -Wound location: Left Lateral Foot; Arterial Ulcer; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Length: 1 centimeter (cm), 0.8 width, depth 0.1 cm; -Wound status: subsequent-Improving; -Dressing change: Every three days. Clean with normal saline. Xeroform, dry dressing. Observation on 6/17/25 at 9:35 A.M., showed LPN L stood at the nursing cart in front of the resident's room. He/She prepared the wound care supplies at the cart, applied gloves, and entered the resident's room. LPN L did not perform hand hygiene prior to applying gloves and did not put on a gown. LPN L removed the resident's left sock. The resident had a dressing to his/her left ankle. LPN L removed the soiled dressing, cleaned the area with the same gloved hands, cut the xeroform with scissors, and applied the xeroform to the wound. LPN L secured the area with a foam bandage. He/She did not change gloves or perform hand hygiene. LPN L cleaned up the trash, removed gloves, and left the resident's room. He/She did not perform hand hygiene after removing gloves and before exiting the room. 3. Review of Resident #9's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -No upper body impairment; -Lower body impairment on both sides; -Dependent (Helper does all effort. Resident does none of the effort to complete activity) for toileting, upper and lower body dressing, and personal hygiene; -Surgical wound; -Diagnoses included diabetes, anxiety, and malnutrition. Review of the resident's care plan, revised on 6/5/25, showed: -Focus: Resident requires EBP related to indwelling urinary catheter and wound; -Goal: Resident will not verbalize or demonstrate symptoms of isolation related to enhanced barrier precautions placement while reducing risk of infection transmission; -Interventions: Appropriate PPE will be utilized during high contact care by care givers (dressing, bathing/showering, transferring in room or therapy gym, providing hygiene, changing linens, changing briefs, or assisting with toileting). Provide education to resident and resident representative as appropriate. Resident is not isolated to their room-they can move around freely. Review of the resident's ePOS, showed an order, dated 6/4/25, cleanse abdomen and dry. Apply collagen pad and soft silicone foam dressing every day shift every other day for wound management. Review of the facility's wound report dated 6/11/25, showed the following for the resident: -Wound location: Midline Abdomen; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Length: 20 cm, 5 cm width, depth 0.1 cm; -Wound status: subsequent-Improving; -Dressing change: Every other day. Clean with normal saline. Xeroform, Collagen Sheet, dry dressing. Observation on 6/17/25 at 9:40 A.M., showed the resident in his/her room. LPN L applied gloves at the treatment cart and used scissors to cut/prep the dressing. LPN L did not put on a gown prior to entering the resident's room. LPN L entered the resident's room and removed the old dressing from the resident's abdomen. He/She cleaned the wound bottom to top with the same gloved hands. LPN L wiped the edges of the wound with a gloved finger and then picked at the top of the resident's wound with the same gloved hand. LPN L applied the xeroform that was cut into 5 small pieces down the resident's abdomen. He/She then secured the wound with two large bandages. One at the top of the wound and one at the bottom. He/She did not change his/her gloves or perform hand hygiene. LPN L cleaned up the trash, removed gloves, and left the resident's room without performing hand hygiene. 4. During an interview on 6/18/25 at 1:20 P.M., LPN L said EBP precautions are to be used for every dressing change. Staff are supposed to place on gown and gloves before providing care if a resident is on EBP precautions. Hand hygiene should be performed before and after each treatment. During an interview on 6/18/25 at 2:30 P.M., LPN B said if a resident is on EBP for wound care, staff are expected to wear gloves, a gown maybe. Nursing staff should wash hands/perform hand hygiene when entering room and before putting on gloves, after removing gloves, and before putting on new gloves. Nursing staff should wash hands in between glove changes when gloves are soiled. During an interview on 6/18/25 at 1:25 P.M., the Director of Nursing said when indicated, EBP is supposed to be used with any type of care like dressing changes. They are to be used to protect the resident from infections. She would expect hand hygiene to be competed on entry into room, when changing gloves, when gloves are soiled and after removing the gloves. Hand hygiene or washing hands should be completed every time staff change gloves. Gloves should be changed between dirty and clean areas. Hand hygiene or hand washing should be performed in-between glove changes.