STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305024	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Manor	40 Whitehall Road Rochester, NH 03867

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, it was determined that the facility failed to follow it's grievance policy for tracking, investigating, and prompt resolution of grievances for 1 out of 1 resident reviewed for grievances (Resident identifiers is #4). Findings include: Interview on 6/4/25 at approximately 11:45 a.m. with Resident #4 revealed that Resident #23 wanders into their room frequently throughout the day and evening and has for some time now. Resident #4 stated they have voiced this concern to staff and nothing has been done to help keep Resident #23 out of their room. Interview on 6/6/25 at approximately 12:15 p.m. with Staff J (Infection Preventionist) stated that on 5/12/25 they spoke to Resident #4 and their roommate regarding Resident #23 wandering into their room. Staff J stated that this information was written up on a grievance form and brought to the managers morning meeting on 5/13/25. Interview on 6/6/25 at approximately 12:30 p.m. with Staff D (Administrator) revealed that the grievance from Resident #4 on 5/12/25 was not logged on the Grievance/Complaint log. Interview with Staff D further revealed that there was no investigation into Resident #4's grievance nor corrective actions taken, if needed. Review on 6/6/25 of the facility policy titledOPS204 Grievance/Concern, revised 10/15/24, revealed . Purpose: to Assure prompt receipt and resolution of patient or representative grievance/concern .4. Upon receipt of the Grievance/Concern Form, the Administrator or designee will document the grievance/concern on the Grievance Concern Log. 5. When the grievance/concern is logged, the Administrator and appropriate departments manager will be notified. 5.1 Immediate action will be taken to prevent further potential violations of any patient rights while the alleged violation is being investigated .6. The department manger will: 6.1 Contact the person filing the grievance to acknowledge receipt; 6.2 Investigate the grievance; 6.3 Take corrective actions, if needed; 6.4 Engage the support of the Ombudsman, if warranted; and 6.5 Notify the person filing the grievance of resolution in a timely manner .

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, it was determined that the facility failed to thoroughly investigate after a resident's fall for 1 of 1 resident reviewed for falls in a final sample of 18 residents. (Resident Identifier is #82). Findings include: Review on 6/6/25 of the facility's policy titled Abuse Prohibition revised on 10/24/22 revealed, .The Center will implement an abuse prohibition program through the following: .Investigation of incidents and allegations; . Reporting of incidents, investigations, and Center response to the results of their investigations .10. At monthly Quality Assurance and Performance Improvement (QAPI) meetings, review all allegations of abuse, neglect, misappropriation of patient property, and exploitation that were reported to the state to: 10.1 Analyze occurrences to determine what changes are needed, if any, to prevent further occurrences; 10.2 Identify situations which a potential for risk; and 10.3 Determine what preventative measures will be implemented by staff. Review on 6/6/25 of Resident #82's Progress Note dated 4/24/25 at 5:22 p.m. and signed by Staff C (Registered Nurse) revealed, Pt's [Patient's] roommate came out in hall looking for a nurse, saying that pt had fallen, Nurse responded immediately, abd [abdomen] pt was found on the ground laying on [pronoun omitted] left side. Pt was unresponsive and not able to follow cues. 911 was immediately notified. Pt was observed to have twitches, and a pillow was applied to under [pronoun was omitted] head. Pt was asked to wait on the floor. 911 was notified. Daughter updated, PA [Physician Assistant] updated, Report called into [Hospital name omitted]. Pt was unable to respond appropriately to questions, Breathing WNL [Within Normal Limits]. Pt. sent with BIPAP [Bilevel Positive Airway Pressure] machine and Daughter called back and was updated on pt's situation. Pt. transferred to [Pronoun omitted] by EMTs [Emergency Medical Technician] at 5:00 p.m. on 4/24/25. Interview on 6/6/25 at 11:00 a.m. with Staff C confirmed the above and revealed that Resident #82 was unresponsive to answering questions. Staff C found Resident #82 by his/her bed so assumed he/she fell out of bed, but is not sure, since the resident was unable to answer any questions. Staff C assessed Resident#82 where he/she had fallen and did not move the Resident #82, but EMS providers arrive within 5 minutes of calling them. Further interview with Staff C on 6/6/25 at approximately 11:00 a.m. revealed that he/she fill in the required incident report and EMS paperwork, but no other paperwork was asked for regarding the fall for an investigation. Interview on 6/6/25 at approximately 10:30 a.m. with Staff B (Director of Nursing) and Staff D (Administrator), revealed that the facility did not attempt to further investigate into the fall to see what the circumstances were. Staff B and Staff D confirmed that neither one had interviewed the roommate or staff after the fall. Staff B and Staff C confirmed the facility had no evidence the facility had interview or investigated the fall. Review on 6/6/25 of the facility's policy titled Falls Management revised on 3/15/24 revealed, . A fall is defined as unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., patient pushes another patient 5. Post-Fall Management: . 5.5 Document circumstances of the fall, post -fall assessment , and patient outcome;

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview, and record review, it was determined that the facility failed to revise a care plan for 1 resident in a final sample of 18 residents (Resident identifiers is #23). Findings include: Interview on 6/4/25 at approximately 11:45 a.m. with Resident #4 revealed that Resident #23 wanders into their room frequently in the evening and night for some time now. Interview on 6/6/25 at approximately 11:45 a.m. with Staff E (Licensed Practical Nurse) stated that Resident #23 will wander into Resident #4's room sometimes. Staff E said the staff will redirect Resident #23 when this occurs. Interview on 6/6/25 at approximately 11:55 a.m. with Staff F (Licensed Nursing Assistant) stated that Resident #23 will wander into Resident #4's room. Staff F said that staff will redirect Resident #23 with items to fidget with and will also try to engage her in activities. Review on 6/5/25 of Resident #23's progress notes revealed the following: On 4/11/25, Resident #23 required frequent redirection as he/she enters other resident's rooms and touches other resident's walkers; On 5/1/25, Resident #23 has been having increased behaviors; On 5/28/25, Resident #23 sleeps intermittently, wanders at night; On 5/29/25, Resident #23 goes into the nurse's station and other residents rooms and Resident #23 can be difficult to redirect and often becomes agitated. Review on 6/5/25 of Resident #23's care plan revealed a care plan, initiated on 10/5/22, for elopement risk related to Cognitive loss/Dementia. Further review of Resident #23's care plan revealed no care plan interventions for wandering into others rooms. Interview on 6/6/25 at approximately 8:50 a.m. with Staff G (Director of Social Services) confirmed that Resident #23 does wander into others rooms and that Resident #23's care plan does not have interventions to address Resident #23's wandering. Review on 6/6/25 of the facility policy titled NSG 206 Behaviors: Management of Symptoms, revised 7/1/24, revealed .Purpose: To identify, prevent and manage behavioral symptoms by: Using non-pharmacological approaches as initial interventions and ongoing; Promoting a therapeutic and safe environment for patients and staff: Monitoring outcomes of care plan interventions. To Minimize the use of psychotropic medications, including antipsychotics, for patients with behavioral symptoms and/or dementia .Practice Standards .2. Staff will monitor for and document in the medical records any exhibited behavioral symptoms .3. Identify, to the extent possible, potential underlying causes of behavioral symptoms .4. Implement individualized, person-centered, non pharmacologic interventions as the initial behavior mitigation strategy and update care plan accordingly .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to follow physician orders for 1 of 4 residents reviewed for medication administration in a final sample of 18 residents (Resident Identifiers is #77). Findings include: [NAME], [NAME] A., and [NAME] [NAME]. Fundamentals of Nursing. 10th edition St. Louis, Missouri: Elsevier, 2021. Page 614 .It is essential to verify the accuracy of every medication you give to your patients with the patient's order. If the medication order is incomplete, incorrect, or inappropriate, or if there is a discrepancy between the original order and the information on the MAR [Medication Administration Record]. consult with the health care provider. Do not give a medication until you are certain that you can follow the seven rights of medication administration . Page 672 .seven rights of medication administration include right medication, right dose, right patient, right route, right time, right documentation and right indication . [NAME], [NAME]; [NAME], [NAME] A.; [NAME], Wendy; and [NAME], [NAME]. Clinical Nursing Skills & Techniques. 10th ed. [NAME], Pennsylvania: Elsevier, 2022. Page 597 - Safe Medication Preparation: Right Time With time-critical medications (e.g., antibiotics, anticoagulants, insulin, immunosuppressives), early or delayed administration of the maintenance doses of more than 30 minutes before or after the scheduled dose will most likely cause harm or result in subtherapeutic responses in a patient. Interview on 6/4/25 at approximately 11:00 a.m. with Resident #77 revealed that his/her short acting insulins are often given late. He/she stated it has happened multiple times since his/her admission within the last month and it didn't matter which meal. He/She indicated one time he/she had chocolate cake by the time the nurse gave him/her their insulin. Review on 6/4/25 of Resident #77's admission's Minimum Data Set (MDS) with an assessment reference date of 5/19/25 revealed Resident #77 had a Basic Interview for Mental Status (BIMS) score of 15 out of 15 indicating cognitively intact. Review on 6/4/25 of the facility's mealtime schedule revealed that breakfast is at 8:00 a.m., lunch is at 12:30 p.m., and dinner is 6:15 p.m. The meals trays are delivered to the individual rooms. Review on 6/5/25 of the manufacturer's instructions for Insulin Lispro revealed Lispro is given within 15 minutes before a meal, or right after eating. Review on 6/5/25 of the manufacturer's instructions for Glargin-ygf revealed .Administer Insulin Glargine-yfgn subcutaneously once daily at any time of day but at the same time every day . Review on 6/4/25 of Resident #77's Location of Administration Report from 5/1/2025 through 5/31/2025 revealed the following days that the short acting insulin was not given per the manufacturer's instructions: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/17/25 HumaLog Kwikpen 100 Unit/ML (milliliters) (Insulin Lispro) (short acting insulin) inject as per sliding scale: if 70 - 150 = 0 units; 151-200 = 2 units; 201- 250= 4 units; 251-300= 6 units; 301-351= 8 units; 351-400 = 10 units> 400 12 units and call provider, subcutaneously before meals for DM (Diabetes Mellitus) was administered at 7:17 p.m. and dinner mealtimes are 6:15 p.m. On 5/21/25 Insulin Lispro 100 unit/ML inject as per sliding scale: 151-200 = 2 units; 201- 250= 4 units; 251-300= 8 units; 301-400= 10 units; 401-402=12 call MD (Medical Doctor) over 400, subcutaneously three times a day for DM, was administered at 6:44 a.m. and breakfast mealtimes at 8:00 a.m. On 5/22/25 Insulin Lispro 100 unit/ML inject as per sliding scale: 151-200 = 2 units; 201- 250= 4 units; 251-300= 8 units; 301-400= 10 units; 401-402=12 call MD 400, subcutaneously three times a day for DM, was administered at 6:51 a.m. and the breakfast mealtimes are 8:00 a.m. On 5/24/25 Insulin Lispro 100 unit/ML inject as per sliding scale: 151-200 = 2 units; 201- 250= 4 units; 251-300= 8 units; 301-400= 10 units; 401-402=12 call MD over 400, subcutaneously three times a day for DM, was given at 6:53 a.m. while the breakfast mealtimes are at 8:00 a.m. On 5/25/25 Insulin Lispro 100 unit/ML inject as per sliding scale: 151-200 = 2 units; 201- 250= 4 units; 251-300= 8 units; 301-400= 10 units; 401-402=12 call MD over 400, subcutaneously three times a day for DM, was given at 6:37 a.m., while the breakfast mealtime is at 8:00 a.m. On 5/26/25 Insulin Lispro 100 unit/ML inject as per sliding scale: 151-200 = 2 units; 201- 250= 4 units; 251-300= 8 units; 301-400= 10 units; 401-402=12 call MD over 400, subcutaneously three times a day for DM, was given at 6:58 a.m., while the breakfast mealtime is at 8:00 a.m. On 5/27/25 Insulin Lispro 100 unit/ML inject as per sliding scale: 151-200 = 2 units; 201- 250= 4 units; 251-300= 8 units; 301-400= 10 units; 401-402=12 call MD over 400, subcutaneously three times a day for DM, was given at 5:59 a.m. and the breakfast mealtime is scheduled for 8:00 a.m. Insulin Lispro 100 unit/ML inject as per sliding scale: 151-200 = 2 units; 201- 250= 4 units; 251-300= 8 units; 301-400= 10 units; 401-402=12 call MD over 400, subcutaneously three times a day for DM, was given at 11:05 and the lunch mealtime is scheduled for 12:30 p.m. On 5/28/25 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Insulin Lispro 100 unit/ML inject as per sliding scale: 151-200 = 2 units; 201- 250= 4 units; 251-300= 8 units; 301-400= 10 units; 401-402=12 call MD over 400, subcutaneously three times a day for DM, was given at 6:10 a.m. and the breakfast mealtime is scheduled for 8:00 a.m. Insulin Lispro 100 unit/ML inject as per sliding scale: 151-200 = 2 units; 201- 250= 4 units; 251-300= 8 units; 301-400= 10 units; 401-402=12 call MD over 400, subcutaneously three times a day for DM, was given at 11:21 a.m. and the lunch mealtime is scheduled for 12:30 p.m. On 5/29/25 Insulin Lispro 100 unit/ML inject as per sliding scale: 151-200 = 2 units; 201- 250= 4 units; 251-300= 8 units; 301-400= 10 units; 401-402=12 call MD over 400, subcutaneously three times a day for DM, was given at 6:48 a.m. and the breakfast mealtime is scheduled for 8:00 a.m. On 5/30/25 Insulin Lispro 100 unit/ML inject as per sliding scale: 151-200 = 2 units; 201- 250= 4 units; 251-300= 8 units; 301-400= 10 units; 401-402=12 call MD over 400, subcutaneously three times a day for DM, was given at 6:45 a.m. and the breakfast mealtime is scheduled for 8:00 a.m. On 5/31/25 Insulin Lispro 100 unit/ML inject as per sliding scale: 151-200 = 2 units; 201- 250= 4 units; 251-300= 8 units; 301-400= 10 units; 401-402=12 call MD over 400, subcutaneously three times a day for DM, it was given at 6:27 a.m. and the breakfast mealtime is scheduled for 8:00 a.m. Insulin Lispro 100 unit/ML inject as per sliding scale: 151-200 = 2 units; 201- 250= 4 units; 251-300= 8 units; 301-400= 10 units; 401-402=12 call MD over 400, subcutaneously three times a day for DM,. it was given at 4:55 p.m. and the dinner mealtime is scheduled for 6:15 p.m. Further Review of Resident #77's Location of Administration Report For May 2025 revealed the following long acting insulins were given more than an hour after the ordered time: On 5/18/25 Insulin Glargine-yfgn (long-acting insulin) 100 units/ML inject 10 unit subcutaneously two times a day for diabetes, was scheduled for 6:00 p.m. and was given at 7:14 p.m. On 5/20/25 Insulin Glargine-yfgn (long-acting insulin) 100 units/ML inject 10 unit subcutaneously two times a day for diabetes, was scheduled for 6:00 p.m. was given at 8:19 p.m. On 5/22/25 Insulin Glargine-yfgn (long-acting insulin) 100 units/ML inject 10 unit subcutaneously two times a day for diabetes, was scheduled for 6:00 p.m. and was given at 7:44 p.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/27/25 Insulin Glargine-yfgn (long-acting insulin) 100 units/ML inject 10 unit subcutaneously two times a day for diabetes, was scheduled for 6:00 p.m. and was given at 7:21 p.m. Review on 6/4/25 of Resident #77's Location of Administration Report from 6/1/2025 through 6/4/2025 revealed the following days that the short acting insulin was not given per the manufacturer's instructions: On 6/1/25 Insulin Lispro 100 unit/ML inject as per sliding scale: 151-200 = 2 units; 201- 250= 4 units; 251-300= 8 units; 301-400= 10 units; 401-402=12 call MD over 400, subcutaneously three times a day for DM, it was given at 6:50 a.m. and the breakfast mealtime is scheduled for 8:00 a.m. On 6/2/25 Insulin Lispro 100 unit/ML inject as per sliding scale: 151-200 = 2 units; 201- 250= 4 units; 251-300= 8 units; 301-400= 10 units; 401-402=12 call MD over 400, subcutaneously three times a day for DM, was given at 6:37 a.m. and the breakfast mealtime is scheduled for 8:00 a.m. Insulin Lispro 100 unit/ML inject as per sliding scale: 151-200 = 2 units; 201- 250= 4 units; 251-300= 8 units; 301-400= 10 units; 401-402=12 call MD over 400, subcutaneously three times a day for DM, was given at 5:44 p.m. and the dinner mealtime is scheduled at 6:15 p.m. On 6/3/25 Insulin Lispro 100 unit/ML inject as per sliding scale: 151-200 = 2 units; 201- 250= 4 units; 251-300= 8 units; 301-400= 10 units; 401-402=12 call MD over 400, subcutaneously three times a day for DM, was given at 6:43 a.m. and the breakfast mealtime is scheduled at 8:00 a.m. On 6/4/25 Insulin Lispro 100 unit/ML inject as per sliding scale: 151-200 = 2 units; 201- 250= 4 units; 251-300= 8 units; 301-400= 10 units; 401-402=12 call MD over 400, subcutaneously three times a day for DM, was given at 6:53 a.m. and the breakfast mealtime is scheduled at 8:00 a.m. Interview on 6/5/25 at approximately 7:00 a.m. with Staff B (Director of Nursing) confirmed that the above medications were administered late. Interview further revealed that Staff B was not notified of the late medications and therefore the physician was not aware. Review on 6/5/25 of the facility's policy titled Medication Administration with a date of 1/25 revealed, Medication Administration: 1. Medications are administrated in accordance with written orders of the prescriber .3. Medication administration timing parameters include the following .b. Medications to be given with meals are to be scheduled for administration at the residents' meal times .14. Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on mealtimes.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interview and record review, it was determined that the facility failed to ensure that trauma survivors have interventions identified to eliminate or mitigate triggers that may cause re-traumatization for 1 of 1 resident reviewed for mood and behaviors in a final sample of 18 residents. (Resident identifier is #4). Findings include: Review on 6/5/25 of Resident #4's Psychiatric note, dated 5/13/25, revealed the following: .[Pronoun omitted] was referred for psychiatric medication management services for depression, anxiety, and PTSD [Post-Traumatic Stress Disorder] .[Name omitted] reports ongoing depressive and anxiety symptoms related to situational stressors .[Pronoun omitted] has also had a difficulty with several residents here and feels uncomfortable around them .[Name omitted] reports chronic nightmares and poor sleep related to childhood molestation .PTSD based symptoms nightmares .Chronic PTSD: chronic nightmares and flashbacks related to childhood sexual abuse perpetrated by her brother, [Name omitted]. Appears to have relational difficulties related to her childhood trauma . Review on 6/5/25 of Resident #4's medical record revealed a care plan, initiated on 3/11/25, that for reported past experience of trauma as evidenced by: Repeated, disturbing memories, thoughts or images of a stressful experience from the related history of abuse. Further review of Resident #4's care plan revealed no identified triggers and interventions. Interview on 6/6/25 at 9:30 a.m. with Staff H (Unit Manager) revealed they were unaware of trauma or PTSD for Resident #4. Interview on 6/6/25 at approximately 11:45 a.m. with Staff E (Licensed Practical Nurse) revealed they were unaware of Resident #4 having trauma. Interview on 6/6/25 at approximately 11:55 a.m. with Staff F (Licensed Nursing Assistant) revealed they were unaware of Resident #4 having trauma. Review on 6/6/25 of Resident #4's admission social services assessment, dated 1/13/25, revealed .C. Mental Health & Wellness .4. Trauma History 1. Does the patient/resident report or does the medical record reflect any history of trauma and /or Post-Traumatic Stress Disorder (PTSD)? YES . 1a 1. if yes select type of trauma and describe using the corresponding comment box .m. Other .m1. Comments car accident and husband passing away . Review on 6/6/25 of Resident #4's quarterly social services assessment, dated 4/9/25, revealed that .C. Mental Health & Wellness .4. Trauma History 2a. Ask: in in the past month , have you had repeated, disturbing memories, thoughts or images of experiences from the past? marked 3. Moderately 2b. Ask: In the past month, have you felt very upset when something reminded you of a stressful experience from the past? Marked 3. Moderately, 5. Comments Mental Health & Wellness Comments a. Use to elaborate on patient's/resident's mental health and wellness: VA [Vehicular Accident] that took place and her husbands passing . (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/6/25 at approximately 9:a.m. with Staff G (Director of Social Services) revealed that Resident #4 has informed them that they have been sexually abused in their childhood, and does not mind male caregivers. Staff G stated that Resident #4 does not like to feel trapped and that is why she has a door bed and not a window. Staff G stated that Resident #4's the care plan does not address the history of sexual abuse or that she does not like to be trapped. Review on 6/6/25 of the facility policy titled SS100 Social Services Assessment revised 3/15/24, revealed . Purpose: To determine the patient's social, functional, emotional, and cognitive status and history of trauma and/or post-traumatic stress disorder (PTSD). To develop an individualized Social Services plan of care.

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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	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, it was determined that the facility failed to implement infection control policies and procedures for 1 of 1 resident observed for wound care in the final survey sample of 18 residents. (Resident identifier is #66). Findings include Observation on 6/4/25 at approximately 10:00 a.m. with Staff A (Licensed Practical Nurse) performing wound care for Resident #66 revealed the following: Staff A entered Resident #66's room and placed wound care supplies on a sterile field on the bedside table. Staff A pulled a pair of scissors out of his/her nursing scrub top pocket and placed it onto the bedside table without disinfecting/cleaning the scissors. Right great toe metatarsal wound care: Staff A donned gloves then proceeded to cut Resident #66's right foot dressing off with the unclean scissors and placed them back onto the bedside table with the wound care supplies. After removing the old dressing, Staff A cleaned the right great toe metatarsal wound with normal saline. Staff A used the unclean scissors to cut the new foam dressing and applied it to the ball of the right great toe and then secured it with a border gauze dressing. Staff A doffed their gloves. Staff A did not change his/her gloves between removing the old dressing and applying the new dressing. Left Plantar Foot wound care: Staff A donned a new pair of gloves. Staff A used the unclean scissors to cut the old dressing off and placed them back onto the bedside table with the wound care care supplies. The left plantar foot wound was cleaned with the wound cleanser. Staff A applied a calcium alginate, covered it with a foam dressing, and secured it with border gauze. Staff A doffed their gloves. Staff A did not change his/her gloves between removing the old dressing and applying the new dressing. Interview on 6/4/25 at approximately 10:30 a.m. with Staff A confirmed the above observations. Review on 6/4/25 of the facility policy titled Wound Dressings: Aseptic, revised 2/24/25, revealed .4. Prepare a clean, uncluttered, disinfected surface. 5. Create an aseptic field at bedside and place clean barrier on over-bed table. Place supplies on barrier .16.1 Apply clean gloves .16.2 Discard soiled dressing and gloves in the appropriate receptacle .18 Apply gloves. Review on 6/4/25 of the CDC's website titled, Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007), retrieved from: https://www.cdc.gov/infection-control/hcp/isolation-precautions/summary-recommendations.html, revealed .Summary of Recommendations .IV. Standard Precautions .IV.A. Hand hygiene .Perform hand hygiene ~ in the following clinical situations: .If hands will be moving from a contaminated-body site to a clean-body site during patient care .After removing gloves .IV.B. Personal protective equipment (PPE) .IV.B.2.Gloves V.B.2.a.Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin (e.g., of a patient incontinent of stool or urine) could occur .IV.B.2.d. Change gloves during patient care if the hands will move from a contaminated body-site (e.g., perineal area) to a clean body-site (e.g., face) .