STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodhaven Nursing Center	1150 Pine Run Drive Lumberton, NC 28358

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident, staff and Medical Director interviews, the facility failed to assess whether the self-administration of medication was clinically appropriate before leaving medications at the bedside. This was for 2 of 2 residents reviewed for medication administration (Resident #3 and Resident #35).Findings included: a. Resident #3 was admitted to the facility on [DATE] with a diagnosis of type 2 diabetes mellitus with diabetic chronic kidney disease, chronic kidney disease, stage 3 unspecified. A review of Resident #3's medical record did not reveal a self-administration of medication assessment. A review of Resident #3's physician's orders from 5/30/25 to 8/22/25 did not reveal a physician's order for Resident #3 to self-administer any medication. A review of Resident #3's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired with no behaviors. The MDS also revealed Resident #3 received antidepressant and hypoglycemic medications. A review of Resident #3's active comprehensive care plan dated 6/10/25 did not have any goals or interventions for Resident #3 to self-administer medications. During an observation and interview with Resident #3 on 8/27/25 at 4:25 PM, resident was observed in bed. Medications were left on her bedside table in a medication cup. There was a total of 3 white pills- 2 were round and 1 was oval shaped. An interview with Resident #3 during the observation revealed she told staff to leave her medications, and she would take her medications later. Resident #3 stated that some nurses would leave the medications, and some would not. On 8/27/25 at 4:40 PM a phone interview with Nurse #1 indicated she was assigned to care for Resident #3 on 8/27/25 from 7:00 AM to 3:00 PM. Nurse #1 stated she was PRN (worked as needed). She indicated that there needed to be a physician's order for residents to self-medicate. There were no residents on her hall who self-medicated. Nurse #1 was aware she left medications in Resident #3's room and she should have taken them out. Per Nurse #1, the resident specifically stated what time she wanted to be bothered and then told her to get out. She went to her cart and left the medications in Resident #3's room. Nurse #1 stated she knew it was wrong and should not have left the medications. Medications left per Nurse #1 were Metformin (diabetic medicine), Amlodipine (blood pressure medicine), and Jardiance (diabetic medicine). Nurse #1 was not aware if Resident #3 had a self-medication assessment, physician order, or care plan related to self-administration of medications. Nurse #1 stated she spoke with the Unit Manager about it once she realized the medications were left in the room. The medications were removed and re-administered at a later time as requested by the resident. Nurse #1 stated the Unit Manager updated the time for Resident #3 to receive medications. 8/28/25 at1:56 PM an interview occurred with the facility's Medical Director. Per the Medical Director, it was expected that medications were not left at the bedside for resident self-administration. Medication administration should be witnessed. b. Resident #35 was admitted to the facility on [DATE] with a diagnosis of type 2 diabetes mellitus without complications, unspecified dementia, unspecified severity, with mood disturbance. A review of Resident #35's medical record did not reveal a self-administration of medication assessment. Assessments were reviewed from 5/6/25 to 8/28/25. A review of Resident #35's physician's orders from 5/6/25 to 8/28/25 did not reveal a physician's order to self-administer any medications. A review of Resident #35's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #35 was cognitively intact with no refusals of care. Resident #35 received antiplatelet, opioids, and antidepressant medications. A review of Resident #35's active comprehensive care plan dated 8/11/25 did not have any goals or interventions for Resident #35 to self-administer medications. On 8/28/25 at 8:45 AM Resident #35 was observed in bed and Nurse #2 left medications on Resident #35's bedside table. Nurse #2 stated to Resident #35 that she needed to get a blood pressure (BP) machine to take the resident's BP and exited the room leaving the medications on the resident's bedside table at 8:47 AM. Resident #35 was observed taking her own medications without Nurse #2 being present. Nurse #2 returned to Resident #35's room at 8:49 AM with the BP machine and took the resident's BP. On 8/28/25 at 9:25 AM an interview with Nurse #2 indicated that if a resident was going to self-administer medications, staff would need to look at the residents' cognition, complete an assessment, and do a return demonstration. Nurse #2 stated she did not know if there were any residents on her hall that self-administered medications. Nurse #2 confirmed she left medications at Resident #35's bedside. She also named the medications that were left at the bedside (Iron, Linzess (constipation), Tylenol, Amlodipine (blood pressure), Aspirin, B12, Colace, Gabapentin (pain), Losartan (blood pressure), Magnesium, Vit D, Effexor (antidepressant), and

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and staff interviews, the facility failed to ensure the daily posting of health care staff form had the correct resident census for 15 of 29 days. The findings included:A review of the facilities daily posting of health care staff from 7/30/2025 through 08/29/2025 revealed the following: a. Daily posting of health care staff dated 7/31/2025 revealed a census of 107. Review of the detailed census report dated 7/31/2025 revealed a census of 104. b. Daily posting of health care staff dated 8/1/2025 revealed a census of 107. Review of the detailed census report dated 8/1/2025 revealed a census of 105. c. Daily posting of health care staff dated 8/2/2025 revealed a census of 106. Review of the detailed census report dated 8/2/2025 revealed a census of 104. d. Daily posting of health care staff dated 8/3/2025 revealed a census of 105. Review of the detailed census report dated 8/3/2025 revealed a census of 102. e. Daily posting of health care staff dated 8/4/2025 revealed a census of 105. Review of the detailed census report dated 8/4/2025 revealed a census of 101. f. Daily posting of health care staff dated 8/6/2025 revealed a census of 103. Review of the detailed census report dated 8/6/2025 revealed a census of 105. g. Daily posting of health care staff dated 8/7/2025 revealed a census of 106. Review of the detailed census report dated 8/7/2025 revealed a census of 107. h. Daily posting of health care staff dated 8/10/2025 revealed a census of 106. Review of the detailed census report dated 8/10/2025 revealed a census of 107. i. Daily posting of health care staff dated 8/11/2025 revealed a census of 106. Review of the detailed census report dated 8/11/2025 revealed a census of 108. j. Daily posting of health care staff dated 8/12/2025 revealed a census of 108. Review of the detailed census report dated 8/12/2025 revealed a census of 109. k. Daily posting of health care staff dated 8/18/2025 revealed a census of 110. Review of the detailed census report dated 8/18/2025 revealed a census of 108. l. Daily posting of health care staff dated 8/20/2025 revealed a census of 108. Review of the detailed census report dated 8/20/2025 revealed a census of 106. m. Daily posting of health care staff dated 8/21/2025 revealed a census of 105. Review of the detailed census report dated 8/21/2025 revealed a census of 107. n. Daily posting of health care staff dated 8/27/2025 revealed a census of 106. Review of the detailed census report dated 8/27/2025 revealed a census of 107. o. Daily posting of health care staff dated 8/28/2025 revealed a census of 107. Review of the detailed census report dated 8/28/2025 revealed a census of 108. An interview with the Staffing Scheduler was conducted on 8/29/2025 at 5:50pm. The Staffing Scheduler revealed she was responsible for completing the daily posting for health care staff. The census number was provided to the Staffing Scheduler during the daily morning meeting from the admission Director. The census included residents in the building as of midnight the prior day. The Staffing Scheduler stated she did not change the daily posting of health care staff if the census changed with any admission or discharges; and was unsure why the census number did not match the daily detailed census report. An interview with the admission Director was conducted on 8/29/2025 at 4:56pm. The admission Director stated every morning she obtained the census number by the total number of residents that were in the building at midnight. She stated the census number provided to her in morning meeting did not include residents who were discharged or admitted . The Administrator was interviewed on 8/29/2025 at 5:21pm. She stated she was unaware of the discrepancy with the census number that was placed on the daily posting of health care staff. The census number posted on the daily posting of health care staff was not the resident census for the day, but the census at midnight.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by the administration of wrong route and medications to be taken with food (5 medication errors out of 31 opportunities), resulting in a medication error rate of 16.13% for 2 of 5 residents observed during medication pass (Resident #24 and Resident #47).The findings included:1. Resident #24 was admitted to the facility on [DATE] with diagnoses that included stroke, hypertension, depression, and respiratory failure. a. A Physician order dated 5/6/25 revealed Resident #24 was to receive folic acid (dietary supplement) one (1) milligram (mg) via gastrointestinal tube (G-Tube) once a day. The order was transcribed on the electronic Medication Administration Record (eMAR) accurately. b. Resident #24's Physician order dated 5/5/25 was reviewed and revealed Resident #24 was to receive docusate sodium liquid (constipation medication) 50mg per 5 milliliters (ml) twice a day via G-Tube. The order was transcribed on the electronic Medication Administration Record (eMAR) accurately. c. Review of Resident #24's Physician order dated 5/6/25 revealed Resident #24 was to receive sertraline (antidepressant) 25mg daily via G-Tube. The order was transcribed on the electronic Medication Administration Record (eMAR) accurately. d. A Physician order dated 5/5/25 revealed Resident #24 was to receive carvedilol (blood pressure medication) 25mg twice a day via G-Tube. The order was transcribed on the electronic Medication Administration Record (eMAR) accurately. e. Review of Resident #24's Physician orders dated 6/25/25 revealed Resident #24 was to receive famotidine (acid reflux medication) 20mg via gastrointestinal tube (a tube inserted through the abdomen to the stomach) twice a day for 90 days. The order was transcribed on the electronic Medication Administration Record (eMAR) accurately. On 8/28/25 at 9:56 AM Nurse #3 was observed preparing Resident #24's medications for administration. She was observed placing folic acid, docusate sodium liquid, sertraline, carvedilol, and famotidine into the medication cup. Review of the resident's electronic MAR during medication pass observation, Resident #24's medications were ordered to be administered via G-Tube. The directions on the medication bottles also stated medications were to be administered via G-Tube. Nurse #3 voluntarily explained that she was advised during morning report that Resident #24 no longer had his G-Tube and that medications were administered orally. Nurse #3 stated she was going to obtain two medications that were not available on her cart. She stepped away from her medication cart at 10:02 AM. On 8/28/25 at 10:04 AM, an interview with Resident #24 confirmed that he still had his G-Tube and that he continued to take his medications via that route. Nurse #3 was not present during that interview with Resident #24. On 8/28/25 at 10:08 AM, Nurse #3 returned to her medication cart without the two medications that were not available. She took the previously filled medication cup containing folic acid, docusate sodium liquid, sertraline, carvedilol, and famotidine into Resident #24's room. Nurse #3 was observed handing Resident #24 his medications to be taken by mouth, the surveyor intervened and stopped Nurse #3 and asked her to step outside into the hall. Resident #24's route of medication was discussed. Nurse #3 explained she reviewed the physician's order on the MAR while preparing Resident #24's medications and was aware the order stated medications were to be administered by a G-tube. However, Nurse #3 stated again that during the morning report, it was reported to her that Resident #24 was on oral medications and that he no longer had his G-Tube. Nurse #3 confirmed she had not assessed the resident prior to administering the medications. During the continued observation Nurse #3 approached the Administrator and Unit Manager as they walked through the hall and asked the Administrator and Unit Manager if the resident's medications were supposed to be administered orally or through G-tube as she was told during the morning report the medications were to be given by mouth. The Administrator and Unit Manager stated they would follow up to confirm. During an interview with Nurse #3 present on 8/28/25 at 10:37 AM, the Unit Manager confirmed Resident #24's G-Tube was still in place, and he continued to receive his medications via G-Tube. The Unit Manager stated the order was verified via call to the Physician's office. 2. Resident #47 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus. A review of Resident #47's medical record indicated an active physician's order dated 6/3/25 for Glucophage Tablet 500 milligrams (mg) (oral diabetes medication), give one (1) tablet by mouth two times a day for diabetes. Take with meals. The order was transcribed on the electronic MAR (eMAR) accurately. On 8/28/25 at 10:50 AM, during medication pass observation, Nurse #3 prepared Resident #47's medications at the medication cart. The medications observed included Glucophage, oxycodone hydrochloride, furosemide, gabapentin, empagliflozin, metoprolol

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and staff interviews, the facility failed to secure a cup of medications stored in 1 of 5 medication carts reviewed for medication storage (medication cart for Hall 1600).The findings included: An observation of the medication cart for Hall 1600 occurred on 8/28/25 at 8:15 AM. The Medication Aide (MA) #1 opened the top drawer of her medication cart and an unlabeled cup of medications was observed in the front left corner of the medication cart drawer. On 8/28/25 at 8:36 AM an interview occurred with MA #1 who confirmed she had left the medications in the top drawer of her medication cart for Resident #121. MA #1 explained the medications were centrum (vitamin supplement), clonazepam (seizure medication), fluoxetine (antidepressant medication), MiraLAX (constipation medication), and modafinil (central nervous system stimulant medication). She explained she had poured the medications and then realized the resident was in the shower, so she placed the medications in the medication cart drawer to provide Resident #121 with the medications later. MA #1 stated she did not know what the proper procedure was but was aware the medications should not have been left in her medication drawer. On 8/29/25 at 4:46 PM an interview occurred the Administrator. The Administrator explained the process for medication storage, stating medication bottles were properly labeled, medications were not to be left out, managers completed periodic audits to check for loose medications, education on medication storage included onboarding during orientation, and then as needed. The Administrator added, the Staff Development Coordinator provided education, and the Director of Nursing oversaw the medication storage process. Per the Administrator, this was reckless behavior on the Nurse's part. She explained MA #1 was new to their facility. The interview further revealed nurses should be prepared to know what to do if they pulled medications that they cannot use.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff, Resident Council and Resident Representative interviews, and test tray, the facility failed to provide palatable foods for 7 of 7 residents reviewed for food palatability (Residents #14, #41, #50, #63, #96, #107 and #109). The findings included:Resident #14 was admitted to the facility on [DATE] with multiple diagnoses that included unspecified dementia and Type 2 diabetes. The medical record indicted Resident #14 resided in the dementia unit. The quarterly Minimum Data Set (MDS) dated [DATE] documented that Resident #14 was severely cognitively impaired. During an interview on 8/26/2025 at 10:58 AM, the Representative of Resident #14 stated she was often there at mealtimes and the Resident complained of the food being cold during those visits. She stated this occurred frequently and most often during breakfast. The representative did not say if she touched or sampled the food to confirm that it was cold. She stated that she had observed the staff taking Resident #14's tray out of the room and heat it up on occasion. An attempt to interview Resident #14 was made but the Resident was unable to describe the palatability of food. On 8/29/25 from 7:57 AM to 8:15 AM, the plating of breakfast food items for the dementia unit was observed. Observations included:-8:13 AM, all resident breakfast plates were placed in individual insulated dome bases and with lids then loaded into an enclosed metal food cart. -8:14 AM, the test tray was plated and placed in the food cart.-8:15 AM, the food cart left the kitchen for delivery to the dementia unit. -8:17 AM the unit staff began serving trays. The test tray food items were sampled and observed in the presence of the Food Service Supervisor on 8/29/25 at 8:32 AM. The observation revealed there was no steam rising from the food when the dome lid was removed and no condensation on the dome lid. The bacon, eggs, grits, and pancakes were all cold to touch and taste. The Food Service Supervisor did not taste the food but touched the pancakes and bacon. During an interview with the Food Service Supervisor on 8/29/25 at 8:34 AM, she stated that food served to residents should be at a temperature that was both safe and that contributed to an enjoyable dining experience. She confirmed the pancakes and bacon that she touched on the test tray were cold to the touch. The Food Service Supervisor also discussed not knowing how to keep the food at the correct holding temperature once the tray was placed on the food cart. She shared that she was not aware of resident complaints of cold food. During the Resident Council meeting on 8/29/25 at 10:28 AM, Resident #41, Resident # 50, Resident #63, Resident #96, Resident #107, and Resident #109 stated that they consistently had to request that staff reheat their meals and that cold food occurred most often at breakfast. On 8/29/25 at 2:36 PM, an interview was conducted with the Administrator who acknowledged awareness of cold food complaints from residents and stated the issues in the kitchen were caused by a combination of new staff, less than ideal staffing levels, lack of training, and the need for repairs to the existing steam table.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review, observations, and staff interviews, the facility failed to ensure dishware was clean, in good condition and not stacked wet, failed to maintain food preparation areas clean and free from dried debris, failed to label and date leftover food stored for use in 1 of 1 walk-in cooler and 1 of 2 walk-in freezers, failed to monitor and record the internal temperatures of food for 2 of 2 tray line observations and failed to ensure hot food was served at or above 135 degrees Fahrenheit (F). These practices had the potential to affect food served to residents.The findings included: a. During the initial tour of the kitchen with the Food Service Supervisor, on 8/26/25 from 9:45 AM to 10:00 AM, the following concerns were observed:- Three out of 8 steam pans that were ready to be used contained yellow and white sticky residue when touched. - Two out of 104 plastic dome lids that were on the tray line ready for use were stacked wet.- Seven out of 24 plates on the tray line ready for meal service had dried, yellow and red residue. - Seven out of 21 sectioned plates on the tray line ready for meal service had dried, yellow residue. - Seven out of 27 stacked serving trays that were on the tray line ready for use were wet and had approximately 50% of the plastic protective covering peeling away, leaving the tray base visible. These findings were discussed with the Food Services Supervisor on 8/26/25 at 10:00 AM and she removed these dishes from service. She stated that the dietary aides were responsible for checking dishes after being washed for overall cleanliness and no dried food particles because there was no designated dish room staff. b. During the initial tour of the kitchen on 8/26/25 from 10:00 AM to 10:30 AM, the food preparation areas were observed and revealed the following:- The entire back splash of the food preparation table (approximately 15 feet) had thick greasy residue and raised dried brown and yellow residue.- The ledge above the stove had visible dried brown and white particles and was covered with thick, shiny residue.- The steam table cover had visible dried brown particles.- The underside of the steam table cover had a thick layer of shiny brown residue and raised, dried, brown residue. - The left side panel of the warmer oven was entirely covered with raised, dried brown and white particles and a thick, shiny residue.- The front panel of the warmer oven had raised, dry black residue approximately half inch wide and dried yellow residue extending from the door handle to the bottom of the panel.- Four out of 5 ceiling level air vents, located on the right wall when entering the kitchen, had black and green raised matter observed on all perimeters and each slat.- A dry storage container labeled fish fry batter had a scoop inside that was submerged under the dry batter mix.These findings were discussed with the Food Services Supervisor on 8/26/25 at 10:00 AM. She shared she and the dietary aides were responsible for cleanliness of the kitchen.c. During the initial tour of the kitchen on 8/26/25 from 10:30 AM to 11:00 AM, the walk-in refrigerator and freezer observations included:- A package of 10 hot dogs wrapped in plastic wrap with no date.- A plastic wrapped package labeled shredded parmesan cheese dated as opened on 8/8/25 and good until 8/14/25.- One clear plastic 10-quart container contained shredded orange soft strips but had no date or label and the top was not secured.- An open bag labeled tator tots was not dated.- A plastic wrapped bag labeled green beans was not dated.- A bag identified by the Food Service Supervisor as French toast was not sealed and had no label and no date.- A plastic wrapped bag identified by the Food Service Supervisor as fried rice had no label and no date. - A three-inch-deep metal baking container identified by the Food Service Supervisor as fish had no label and no date. During an interview with the Food Service Supervisor on 8/26/25 at 11:49 AM, she stated that all food items should be sealed, labeled, and dated when stored. She stated all dietary aides were to check food items daily and immediately discard any items that were not sealed, labeled, or dated but labeling and cleaning the kitchen was a challenge with limited staff. d. On 8/28/25 at 11:49 AM during an observation of the lunch tray line, [NAME] #1 was asked to test the internal temperatures of the lunch food items. [NAME] #1 used a thermometer to test the internal temperature. There were two pans of meatloaf; pan #1 was noted to be 130.4 degrees Fahrenheit (F) and pan #2 was 114 degrees F. [NAME] #1 reported she thought the internal temperature was supposed to be 140 degrees F and stated the food would need to be reheated. The Food Service Supervisor was notified of the meatloaf's temperature on 8/28/25 at 11:50 AM and the items were removed and put back in the oven to reheat. When the pans of meatloaf were removed, no steam was observed rising from the middle section of the steam table, but steam was observed in the two other sections of the steam table. [NAME] #1 and the Food Service Supervisor were interviewed on 8/28/25 at 12:00 PM and they both stated the middle section of the steam table did not hold temperatures; the water would stay warm but not hot. The Food Service Supervisor stated the Administrator was aware of the steam table issues. She stated a Corporate Maintenance Director had

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews the facility failed to implement their infection control policies when Nurse #2 did not don (put on) a gown while administering medications via a gastrointestinal tube (a tube inserted through the abdomen to the stomach) to Resident #37 who required enhanced barrier precautions (EBP) due to the presence of a gastrointestinal tube (G-tube). This practice occurred for 1 of 3 staff members observed for infection control.The findings included: Review of the facility's Enhanced Barrier Precautions door sign dated 1/20/2022 stated that all healthcare personnel must wear gloves and gown for the following High Contact-Resident Care Activities: Device care or use: central line, urinary catheter, feeding tube, and tracheostomy care. Review of the facility's Infection Prevention and Control Standards policy (last approved 11/2024), and the Initiating Transmission Based Precautions policy (last approved 06/2025) stated Transmission-Based Precautions will be utilized in addition to Standard Precautions when the route of transmission is not completely interrupted using Standard Precautions alone. This type of Transmission-Based Precautions includes Enhanced Barrier Precautions. Additional policy and procedures include Appropriate use of personal protective equipment. An observation of Resident #37's door on 8/28/25 at 9:00 AM revealed a sign taped on the door indicating she was on Enhanced Barrier Precautions (EBP) and a [NAME] containing gowns and gloves was hanging on the door. Nurse #2 was observed entering Resident #37's room to administer medications via G-tube without donning a gown. Once Nurse #2 was in the room, she donned her gloves, pulled the resident's bedding back to expose the G-Tube. She then obtained the syringe from the protective bag hanging from a pole, began detaching the catheter from the G-Tube and placing it over the pole. Nurse #2 placed one end of the syringe into the G-Tube and began administering Resident #37's medication. When Nurse #2 had completed providing Resident #37 with her medication, she attached the catheter back to the G-Tube, covered the resident with her bedding, washed the syringe, placed it back into the protective bag, and left the room. On 8/28/25 9:25 AM an interview occurred with Nurse #2. Nurse #2 discussed being an agency nurse and that it was her second time working in the facility. She confirmed Resident #37 was on Enhanced Barrier Precautions (EBP). She also confirmed she did not put on a gown when providing medications through Resident #37's feeding tube. Nurse #2 stated she was aware she should have gowned but just forgot. On 8/29/25 at 2:20 PM an interview was held with the Staff Development Coordinator (SDC)/Infection Preventionist (IP). She explained if agency staff were not present when education was provided to all staff, the information was provided to the agency to follow up with agency staff. Documentation of the completed training was required, and proof must be given to the facility. If agency staff were new to their facility, education was completed prior to staff arriving at work. The SDC/IP sometimes provided education when the agency staff arrived onsite prior to them starting their assignment and EBP was included in the infection control education. The SDC/IP stated staff were required to wear a gown and gloves while performing direct care, including G-tubes. Nurse #2 was educated during orientation, before she went onto the floor, and afterwards. The SDC/IP discussed Nurse #2 was educated on EBP on 8/23/25, and on contact versus enhanced precautions on 8/28/25. The SDC/IC provided evidence of orientation education for Nurse #2. On 8/29/25 at 4:46 PM an interview occurred with the Administrator. The Administrator stated the process for donning gowns during tube feedings/Infection Control was that staff must wear a gown and signs were on the door. Management also routinely spoke with staff during their staff meetings regarding infection control. The Staff Development Coordinator provided education on infection control. The Administrator stated there was no excuse why the nurse did not wear a gown. The Administrator stated she had quarterly facility-wide meetings regarding infection control, and the department heads/unit managers have monthly department meetings as well. The facility also had staff huddles as needed to provide education related to infection control.