STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365705	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aventura at Walton Hills	19859 Alexander Rd Walton Hills, OH 44146

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on record review, interview and facility policy review, the facility failed to ensure care plans were individualized for Resident #33. This affected one resident (#33) out of three residents reviewed for care plans. The facility census was 71. Findings include: Review of the medical record for Resident #33 revealed an admitted [DATE]. Diagnoses included paraplegia, neuromuscular dysfunction of bladder, neurogenic bowel, history of COVID-19, colostomy, and cannabis dependence. Review of Resident #33's care plan dated 10/23/24 revealed there was no care plan for the recent unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) acquired in house on 12/05/24. Interview on 03/25/25 at 2:33 P.M. with Regional Director of Clinical Operations (RDCO) #400 confirmed there was no care plan for the recent in house acquired unstageable pressure ulcer for Resident #33 and/or updated interventions. Review of the facility policy, Care Plans, Comprehensive Person-Centered, revised December 2016, revealed the comprehensive, person-centered care plan includes identified problem areas and measurable objectives and timeframes. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. This deficiency is an incidental finding identified during the complaint investigation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on record review, interview and facility policy review, the facility failed to ensure weekly skin observations were accurately completed as ordered for Residents #33 and #72. This affected two residents (#33 and #72) out of three residents for wounds. The facility census was 71. Findings include: 1. Review of Resident #33's medical records revealed an admitted [DATE]. Diagnoses included paraplegia, neuromuscular dysfunction of bladder, neurogenic bowel, history of COVID-19, colostomy, and cannabis dependence. Review of Resident #33's physician orders for March 2025 revealed an order to cleanse the right lateral ankle with normal saline (NS) or wound cleanser, pat dry, apply collagen to the wound and cover with boarder gauze every Monday, Wednesday, and Friday night shift and as needed (PRN). Review of Resident #33's Medication Administration Record (MAR) and Treatment Administrative Record (TAR) for October 10/23/24 revealed wound treatment was current for Stage 3 pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) to the right outer ankle and deep tissue injury (DTI) (A purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue due to pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.) to the right heel. Review of the Braden Scale for predicting Pressure Ulcers dated 12/05/24 revealed Resident #33 was at low risk for pressure ulcers. Review of the care plan dated 10/23/24 revealed Resident #33 was actual/potential for skin integrity impairment related to immobility and obesity and listed on admission a Stage 3 pressure ulcer on the coccyx, healed on 11/05/24, and present on admission a Stage 3 pressure ulcer to the left ischium healed on 11/05/24. The care plan did not include the pressure ulcer to the right lateral ankle, or the pressure ulcer right heel. There were no interventions/revisions noted for the right lateral ankle or the right heel pressure ulcers. Review of the progress note for Resident #33 dated 12/05/24 at 1:03 P.M. revealed an open area was noted to the right outer ankle. First aid was initiated and the physician, nurse practitioner (NP), Director of Nursing (DON), and the wound nurse were notified. An order for Resident #33 to be referred to the wound physician was obtained. Review of the weekly skin observations for Resident #33 revealed for 11/15/24 he had no skin issues. The next weekly skin observation was not completed until 12/05/24 which had no skin issues noted. The weekly skin observations for 01/07/25 and 01/14/25 revealed the right heel pressure ulcer and the right lateral ankle pressure ulcers with no measurements. The weekly skin observations for 02/04/25, 02/07/25, 02/11/25, 02/14/25 revealed the right lateral ankle pressure with no measurements. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were no weekly skin observations documented for March 2025 for Resident #33. Interview on 03/19/25 at 2:24 P.M. with Regional Director of Clinical Operations (RDCO) #400 confirmed weekly skin observations were to be completed every week, and the form was to be completed accurately to include the type of skin/pressure ulcer and the measurements. RDCO #400 verified Resident #33 did not have weekly skin observations completed for some days, and some were done incorrectly. RDCO #400 verified no weekly skin observations were completed for March 2025. Interview on 03/19/24 at 3:00 P.M. with Wound Nurse (WN)/Assistant Director of Nursing (ADON) #205, who was new to the position, confirmed weekly skin observations were to be done every week, and the form was to be completed accurately to include the type of skin/pressure ulcer and the measurements. WN/ADON #205 verified Resident #33's weekly skin observations were not done correctly and/or were not done at all. WN/ADON #205 verified Resident #33 did not have any weekly skin observations for March 2025. 2. Review of Resident #72's closed medical record revealed an admitted [DATE] and a discharge date of [DATE]. Diagnoses included acute duodenal ulcer with hemorrhage, acute posthemorrhagic anemia, acute respiratory failure with hypoxia, morbid severe obesity, irritant contact dermatitis, and atrial fibrillation. Review of Resident #72's Braden Scale for predicting Pressure Ulcers risk dated 02/06/25 revealed she was at moderate risk for skin breakdown. Review of Resident #72's admission evaluation for skin dated 02/06/25 revealed she had no skin issues except bilateral lower extremity discoloration. Review of the admission progress note dated 02/06/25 at 6:45 P.M. authored by Licensed Practical Nurse (LPN) #221 revealed Resident #72 had no skin issues except bilateral discoloration to lower extremities. Review of the care plan dated 02/07/25 revealed Resident #72 was at risk for actual and potential skin integrity impairment related to immobility and incontinence. Interventions included applying barrier cream after incontinence, assessing pain before, during, and after treatments, encourage the resident to get out of bed to the wheelchair daily, encourage the resident to turn and change position every two hours, keep skin clean and dry, wound consultant and follow up PRN. Review of Resident #72's Minimum Data Set (MDS) modification of admission assessment dated [DATE] revealed the resident had intact cognition. Resident #72 was independent for bathing, required substantial assistance for oral hygiene, and was dependent on staff for toileting hygiene, showers, dressing, and personal hygiene. Resident #72 was occasionally incontinent for urine and always incontinent for bowels. Review of Resident #72's physician orders dated February 2025 revealed an order dated 02/06/25 for Nystatin external powder 100000 Unit/Gram (unit/gm) (treats fungal or yeast infections of the skin) topical apply to skin folds topically two times a day (BID) for excoriation. On 02/10/25 a new order was obtained for Nystatin external powder 100000 unit/gm topical apply to skin folds topically two times a day (BID) for excoriation for 14 days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR and TAR for February 2025 revealed Nystatin external powder was administered on 02/06/25 and discontinued on 02/10/25. Started back up on 02/10/25 until 02/24/25. Review of Resident #72's weekly skin observation assessment revealed only one skin assessment was completed on 02/14/25, which revealed no skin issues. Interview on 03/19/25 at 2:24 P.M. with RDCO #400 verified weekly skin observations were to be done every week on every resident, and the form was to be completed accurately to include the type of skin/pressure ulcer and the measurements. RDCO #400 verified Resident #72 only had one weekly skin assessment completed on 02/14/25. Interview on 03/20/25 at 3:00 P.M. with Wound Nurse/ADON #205 revealed the only weekly skin assessment completed for Resident #72 was on 02/14/25, and it did not identify any skin issues. WN/ADON #205 verified the weekly skin assessments were not completed as required and should be done on all residents every week. Wound Nurse/ADON #205 verified Resident #72 did not have a weekly skin assessments performed on 02/21/25, 02/28/25, and 03/07/25 before discharge. Review of the facility policy, Pressure Ulcer/Injury Care and Management, revised 08/2022, revealed weekly skin audits will be performed on all residents. This deficiency represents non-compliance investigated under Master Complaint Number OH00163632.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43061 Based on observation, record review, facility policy review and interview, the facility failed prevent Resident #58 from developing an in-house pressure ulcer and failed to ensure timely identification, proper treatment and interventions were initiated to promote healing. Additionally, the facility failed to ensure nursing staff completed accurate and comprehensive weekly skin assessments/checks as ordered. Actual Harm occurred on 12/04/24 when the facility failed to implement appropriate and effective interventions for Resident #58, who was at risk for developing pressure ulcers, was always incontinent of bladder, frequently incontinent of bowel, and required staff assistance for activities of daily living, to prevent the development of an in-house acquired unstageable (full-thickness tissue loss in which the base of the ulcer is covered by slough or and/or eschar making the depth/stage undetermined) pressure ulcer to the left buttocks. This affected one resident (#58) of three residents reviewed for pressure injuries/skin impairments. The facility identified five residents (#1, #17, #33, #58, and #63) with pressure ulcers. The facility census was 71. Findings include: Review of Resident #58's medical record revealed an admitted [DATE] with diagnoses including type II diabetes mellitus (DM), schizophrenia, pressure ulcer of left buttock and secondary Parkinsonism. Review of a plan of care initiated on 03/09/18 revealed Resident #58 had a potential for skin breakdown related to fragile skin and impaired mobility. Interventions included Braden Scale per protocol, complete skin assessment per protocol, encourage turning and repositioning, pressure reducing mattress to bed, and pressure releasing devices as indicated. Record review revealed no documented evidence staff encouraged or provided turning and repositioning of the resident. Review of Resident #58's medical record revealed a physician's order dated 05/03/24 for skin checks weekly every day shift every Monday. Review of Resident #58's weekly skin observations/assessments dated 11/11/24 and 11/13/24 revealed the resident had no skin issues. Review of Resident #58's weekly skin observation dated 11/19/24 revealed staff documented the resident had a skin abrasion to the left buttock that measured 3.0 centimeters (cm) by 3.0 cm and documented as N/A for stage. Review of a progress note dated 11/19/24 at 10:45 P.M. revealed Resident #58 had a 3.0 cm by 3.0 cm by 0 cm abrasion on left buttock. Resident #58 had complaints of left buttock pain and as needed (PRN) medications were administered. However, the record review revealed there was no documented evidence pain medication was administered on the medication administration record (MAR) on 11/19/24. The note revealed a treatment was applied. However, there was no documented evidence of what treatment was applied. Notifications were made to the physician, Director of Nursing (DON), and family. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Braden Scale for Predicting Pressure Ulcers dated 11/20/24 revealed a score of 20.0 which indicated Resident #58 was risk for developing pressure ulcers. There was no documented Braden Scale completed before 11/19/24. Review of an interdisciplinary team (IDT) progress note dated 11/20/24 revealed Resident #58 had a reddened area to the left buttock. The left buttock skin was intact but noted to be non-blanchable. Notifications were made to the physician, DON, and family. The note indicated the wound physician was notified and would follow up with the resident on the next scheduled visit. An initial intervention included to pad and protect the left buttock. No additional interventions were noted to be implemented at that time. Review of physician orders and treatment administration records (TAR) revealed from 11/20/24 to 11/22/24 an order was in place to cleanse the resident's coccyx (although the wound was on the left buttock) with normal saline (NS) and apply a clean dry dressing (CDD) every night shift (HS). A new order was obtained on 11/24/24 to cleanse the left buttock/coccyx with NS, pat dry, cover with a CDD every night shift. This order remained in place from 11/24/24 until it was discontinued on 12/03/24. Review of Resident #58's weekly skin observation dated 11/25/24 revealed no skin issues were documented on the form. Review of Resident #58's weekly skin observation dated 12/02/24 revealed the resident had a left buttock pressure ulcer; however, there were no measurements or description of the wound. Review of a Wound Physician Note dated 12/04/24 (first visit by the wound physician) revealed Resident #58 had an unstageable pressure to the left buttock that measured 2.5 cm in length by 2.4 cm width with a depth that could not be determined (UTD). The wound bed tissue composition at the beginning of visit was 10% granulation, 10% slough, and 80% eschar. Minimal exudate and erythema were noted. A new treatment to use hydrogel gauze, cleanse wound with NS or sterile water, apply to the wound bed and cover with a dry clean dressing was noted in the progress note. Review of Resident #58's medical record revealed physician's orders dated 12/05/24 for Pro-Stat (protein supplement) two times a day (BID) give 30 milliliters (mL) for wound healing and an order for a pressure reducing cushion to the resident's wheelchair. Review of the care plan initiated 12/06/24 revealed Resident #58 had actual skin breakdown related to mobility deficit. Resident #58 had an unstageable deep tissue injury (DTI) (A purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue due to pressure and/or shear to the left buttock (12/03/24). Interventions initiated on 12/06/24 (following the identification of the pressure ulcer) included consulting a wound consultant and follow up as needed (PRN), encourage turning and repositioning every two hours while in bed, low air loss mattress, minimizing exposure to excessive moisture or stool, nutritional interventions as ordered, and wound care as ordered. The care plan was updated on 12/31/24 to reflect the pressure ulcer was a Stage III (full thickness tissue loss, subcutaneous fat may be visible, but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) pressure ulcer. Review of Resident #58's medical record revealed a physician's order dated 12/06/24 for a low air loss mattress. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #58's weekly skin observation dated 12/09/24 revealed the resident had a left buttock pressure ulcer; however, there were no measurements or description of the wound. Review of Resident #58's weekly skin observation dated 12/16/24 revealed the resident had a left buttock pressure ulcer; however, there were no measurements or a description of the wound. Review of the Wound Physician Note dated 12/18/24 revealed Resident #58 had a pressure injury on the left buttock that measured 2.5 cm by 2.4 cm by width UTD. The wound bed tissue composition was 10% granulation, 10% slough, and 80% eschar. Minimal exudate and erythema were noted. The treatment was to include 0.25% Dakin's moistened gauze every day and PRN. The healing status stated declined. Review of Resident #58's weekly skin observation dated 12/20/24 revealed no skin issues were documented on the form. Review of Resident #58's weekly skin observation dated 12/23/24 revealed the resident had a left buttock pressure ulcer; however, there were no measurements or a description of the wound. Review of Resident #58's Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #58 had intact cognition. She had no behaviors of rejection of care and had limitations to range of motion of the upper and lower extremities bilaterally. The assessment revealed the resident required supervision or touching assistance with toileting hygiene, showers, rolling left to right and transfers. She required partial to moderate assistance with lower body dressing and personal hygiene and was dependent on staff for putting on/taking off footwear. The assessment revealed the resident was always incontinent of bladder and frequently incontinent of bowel, was at risk for pressure ulcer development and had a Stage III pressure ulcer. Review of Resident #58's weekly skin observation dated 01/06/25 revealed the resident had a left buttock pressure ulcer; however, there were no measurements or a description of the wound. Review of Resident #58's weekly skin observation dated 01/13/25 revealed the resident had a left buttock pressure ulcer; however, there were no measurements or a description of the wound. Review of Resident #58's weekly skin observation dated 01/20/25 revealed the resident had a left buttock pressure ulcer; however, there were no measurements or a description of the wound. Review of Resident #58's weekly skin observation dated 01/27/25 revealed the resident had a left buttock pressure ulcer; however, there were no measurements or description of the wound. Review of Resident #58's weekly skin observation dated 01/29/25 revealed the resident had a left buttock pressure ulcer; however, there were no measurements or a description of the wound. Review of Resident #58's weekly skin observation dated 02/05/25 revealed the resident had a left buttock pressure ulcer; however, there were no measurements or description of the wound. Review of Resident #58's weekly skin observation dated 02/10/25 revealed the resident had a left buttock pressure ulcer; however, there were no measurements or description of the wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #58's weekly skin observation dated 02/14/25 revealed no skin issues were documented on the form. Review of Resident #58's weekly skin observation dated 02/17/25 revealed the resident had a left buttock pressure; however, there were no measurements or description of the wound. Review of Resident #58's weekly skin observation dated 02/19/25 revealed no skin issues were documented on the form. Review of Resident #58's weekly skin observation dated 02/20/25 revealed no skin issues were documented on the form. Review of Resident #58's weekly skin observation dated 02/24/25 revealed no skin issues were documented on the form. Review of Resident #58's weekly skin observation dated 03/03/25 revealed the resident had a left buttock other, wound; however, there were no measurements or a description of the wound. Review of Resident #58's weekly skin observation dated 03/10/25 revealed no skin issues were documented on the form. Review of Resident #58's weekly skin observation dated 03/17/25 revealed no skin issues were documented on the form. Record review revealed during this time period, the resident was being seen by the Wound Physician who did include measurements of the wound when the resident was seen. On 03/19/25 at 2:24 P.M. an interview with Regional Director of Clinical Operations (RDCO) #400 verified weekly skin observations were to be done every week, and the form was to be completed accurately to include the type of skin/pressure ulcer and the measurements of the pressure ulcer/wound. On 03/19/25 at 3:00 P.M. an interview with Wound Nurse (WN)/Assistant Director of Nursing (ADON) #205, who was new to the position, verified weekly skin observations were to be done every week by the nurses working the floor, despite the Wound Physician's weekly assessments, and the form was to be completed accurately to include the type of skin/pressure ulcer and the measurements. WN/ADON #205 verified weekly skin observations were not completed correctly for Resident #58. During the interview, she was also unable to provide a reason why some of the nurse's weekly skin observations showed no wounds when Resident #58 did in fact have a pressure ulcer to the left buttocks. In addition, during the interview WN/ADON #205 also revealed she would not expect an abrasion to turn into an unstageable pressure wound before additional interventions were implemented. No investigation was conducted by the facility to determine how the left buttock abrasion deteriorated from an abrasion to an unstageable pressure ulcer without staff knowledge before it became unstageable. WN/ADON #205 verified Resident #58's pressure ulcer to the left buttock was an in-house acquired unstageable pressure ulcer identified by the wound physician on 12/04/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Observation on 03/20/25 at 12:47 P.M. of wound care revealed Licensed Practical Nurse (LPN) #211 performed hand hygiene, gathered supplies, donned personal protective equipment (PPE), knocked on door and entered. LPN #211 disinfected the over the bed tray and applied a barrier. Gloves were removed, hand hygiene performed, and new gloves applied. Resident #58 was in bed, and LPN #211 assisted in removing the resident's pants and brief. LPN #211 removed the resident's old dressing which had moderate dry drainage noted. An open area with some darkness was observed to the left buttock. LPN #211 cleansed with wound normal saline, patted the wound dry, applied collagen alginate with silver and covered with a dressing with date and initials. LPN #211 assisted Resident #58 with reapplying her brief and pants and assisted her to her chair. Infection control was maintained throughout the procedure, and Resident #58 tolerated with no complaints. LPN #211 doffed PPE before exiting the room. Review of the facility policy, Pressure Ulcer/Injury Risk Assessment, revised 07/2017, revealed the purpose of this procedure was to provide guidelines for the structures assessment and identification of residents at risk of developing pressure ulcers/injuries. The purpose of the risk assessment was to identify all risk factors and determine which could be modified, which could not, or which could be immediately addressed. Review of the facility policy, Pressure Ulcer/Injury Care and Management, revised 08/2022, revealed residents would receive care consistent with professional standards of practice, to prevent pressure ulcer/injury. Residents would receive necessary treatment and services, consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing. This deficiency represents non-compliance investigated under Master Complaint Number OH00163632.

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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** 43061 Based on observation, interviews, record review and facility policy review, the facility failed to ensure infection control measures were maintained during medications administration, which included hand washing/hand hygiene. This affected three residents (#4, #20, and #71) out of six residents observed for medication administration and had the potential to affect 16 additional residents (#3, #5, #10, #22, #23, #24, #28, #30, #31, #35, #39, #41, #44, #46, #66, and #67) on Licensed Practical Nurse (LPN) #215's assignment. The facility census was 71. Findings include: 1. Review of the medical record for Resident #4 revealed an admitted [DATE]. Diagnoses included hemiplegia and hemiparesis following cerebrovascular disease, type II diabetes mellitus, and vascular dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 had intact cognition. Observation on 03/19/25 at 8:53 A.M. revealed LPN #215 began to prepare the medications for Resident #4 without performing hand hygiene. After placing all the medications in the medicine cup, she entered the resident's room and administered the medication to her. Upon leaving the room, LPN #215 did not perform hand hygiene and proceeded to prepare medications for the next resident (Resident #20). 2. Review of the medical record for Resident #20 revealed an admitted [DATE]. Diagnoses included hypertensive heart and chronic kidney disease with heart failure, chronic kidney disease (CKD) stage 3b, history of COVID-19, and heart failure. Review of the quarterly MDS assessment dated [DATE] revealed Resident #20 had intact cognition. Observation on 03/19/25 at 8:55 A.M. revealed LPN #215 began to prepare the medications for Resident #20 without performing hand hygiene. One of the medications was Artificial Tears eye drops. After placing all the medications in the medicine cup, she entered the resident's room and administered the medication. She then put on gloves, without performing hand hygiene first, and administered Artificial Tears eye drops, one drop in each eye. After administering the eye drops, she removed her gloves and exited the room without performing hand hygiene and proceeded to the next resident (resident #71). 3. Review of the medical record for Resident #71 revealed an admitted [DATE]. Diagnoses included Alzheimer's disease with late onset, adult failure to thrive, dementia, and vitamin b12 deficiency anemia. Review of the quarterly MDS assessment dated [DATE] revealed Resident #71 had severely impaired cognition. (continued on next page)

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Aventura at Walton Hills	19859 Alexander Rd Walton Hills, OH 44146

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 - Some	Observation on 03/19/25 at 9:07 A.M. revealed LPN #215 began to prepare the medications for Resident #71 without performing hand hygiene. After placing all the medications in the medicine cup, she entered the resident's room and administered the medication. After exiting the room, she did not perform hand hygiene. Interview on 03/19/25 at 9:13 A.M. with LPN #215 verified she did not perform hand hygiene during medication administration before or after administering resident medications or before or after removing her gloves from administering eye drops. Interview on 03/19/25 at 12:41 P.M. with Regional Director of Clinical Operations (RDCO) #400 verified hand hygiene was to be performed before and after each medication pass and before and after donning/doffing gloves. Review of the undated facility policy, Infection Prevention and Control Program revealed hand hygiene protocol to include all staff shall wash their hands between resident contacts, and before and after performing resident care procedures. Review of the undated facility policy, Hand Hygiene Policy and Procedure revealed indications for handwashing to include before having direct contact with patients, and after removing gloves. Review of the facility policy, Administering Medications, revised December 2012, revealed staff shall follow established facility infection control procedures to include handwashing for the administration of medications. Review of the facility policy, Instillation of Eye Drops, revised January 2014, revealed to wash hands thoroughly and don gloves. After administering eye drops remove the gloves and wash hands thoroughly. This deficiency is an incidental finding identified during the complaint investigation and is a recite to the complaint survey completed 02/11/25.