STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366364	A. Building B. Wing	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Triple Creek Retirement Community	11230 Pippin Road Cincinnati, OH 45231

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 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 record review, interview, and facility policy review, the facility failed to notify a physician of the facility's failure to administer ordered medications in a timely manner to three (Residents #46, #107, and #199) of four residents reviewed for notification of changes. Additionally, the facility failed to notify the Infectious Disease specialist of the addition of an antifungal medication for Resident #107. The facility census was 50. Findings included:1. Review of Resident Face Sheet revealed the facility admitted Resident #199 on 02/08/2025 with diagnoses of cellulitis of the right and left lower limbs and methicillin-resistant Staphylococcus aureus (MRSA) infection. Review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/13/2025, revealed Resident #199 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. The MDS indicated Resident #199 did not reject care during the assessment's lookback period. The MDS revealed the resident had intravenous (IV) access on admission and while a resident. The MDS indicated Resident #199 admitted from a short-term general hospital. Revie of Resident #199's Care Plan History, included a problem statement dated 02/19/2025, that indicated the resident required enhanced barrier precautions (EBP) during high-contact care related to the presence of a wound with dressing changes. Interventions directed staff to observe for and report any new or worsened signs/symptoms of infection. Review of Resident #199's Out-patient antibiotic therapy ([NAME])/Antibiotic Infusion orders, dated 02/07/2025, indicated the resident was to receive IV meropenem (an antibiotic) 1 gram (g) every eight hours and linezolid (an antibiotic), 600 milligrams (mg) by mouth every 12 hours, to complete 02/21/2025. The [NAME]/Antibiotic Infusion orders, indicated Resident #199 had bilateral leg wounds with a polymicrobial infection including MRSA infection. Review of Resident #199's View Prescription Order, received 02/09/2025 and started 02/10/2025, revealed a written physician's order for meropenem 1 g IV every eight hours, first administration time 12:00 A.M. Review of Resident #199's Physician Order Report, dated from 02/01/2025 through 07/02/2025, included an order for meropenem 1 g IV every eight hours at 12:00 A.M., 8:00 A.M., and 4:00 P.M., started on 02/10/2025. The Physician Order Report included an order for linezolid 600 mg by mouth every 12 hours for 14 days, started on 02/09/2025. Review of Resident #199's 02/2025 Medication Administration History revealed meropenem was not administered as scheduled on 02/10/2025 at 12:00 AM or 8:00 A.M. The Medication Administration History revealed staff documented that they administered the meropenem late on 02/10/2025 at 12:57 P.M. Further review revealed linezolid was not administered as scheduled on 02/09/2025 and 02/10/2025 from 7:00 A.M. to 11:00 A.M. The Medication Administration History revealed staff documented that they administered linezolid late on 02/10/2025 at 12:57 P.M. During an interview on 07/08/2025 at 2:06 P.M., the Medical Director (MD) stated he was unaware that Resident #199's IV antibiotics were not started on admission but two days after admission. The MD stated he expected medications to be available to be administered as ordered and to be notified if medications could not be administered so the orders could be potentially modified or to provide further instructions, because when antibiotics were missed it resulted in a delay in treatment. On 07/11/2025 at 7:28 A.M., interview with the Director of Health Services (DHS) revealed they would call the doctor to see what they could do if they were not able to get the resident's medications right away. The DHS stated they should have gotten an order from the doctor as to when they wanted them to start medications for Resident #199. 2. Review of the Resident Face Sheet revealed the facility admitted Resident #107 on 03/20/2025 at 6:55 PM. with diagnoses of cellulitis of the right upper and lower limb, gangrene, Group B Streptococcus (a bacteria), aftercare following a surgical amputation, and acquired absence of the right finger. Review of the admission Minimum Data Set (MDS), with an admission Reference Date (ARD) of 03/24/2025, revealed Resident #107 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS also indicated that the resident did not reject care during the assessment's lookback period. The MDS revealed the resident received intravenous (IV) medications while a resident. The MDS indicated Resident #107 admitted from a short-term general hospital. Review of Resident #107's Care Plan History, included a problem statement dated 03/24/2025, that indicated the resident required enhanced barrier precautions (EBP) during high-contact care related to the presence of a wound with dressing changes and a central line. Interventions directed staff to observe for and report any new or worsened signs/symptoms of infection. Review of a physician's ID [Infectious Disease] progress note, dated 03/20/2025 and electronically signed on 03/20/2025 at 9:26 AM, indicated Resident #107 had a right

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to ensure a safe, clean, comfortable, and homelike environment by failing to ensure an intravenous (IV) pole utilized for tube feeding was clean for one (Resident #27) of two residents reviewed for tube feeding. The facility census was 50. Findings included:Review of Resident Face Sheet revealed the facility admitted Resident #27 on 01/17/2025 with diagnoses of cerebral palsy and dysphagia (difficulty swallowing). Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/25/2025, revealed Resident #27 had moderate impairment in cognitive skills for daily decision-making and had short-term and long-term memory problems per a Staff Assessment for Mental Status (SAMS). The MDS indicated that the resident required substantial to maximal assistance with eating and indicated the resident had a feeding tube. The MDS indicated the resident received greater than 51% of their total calories via feeding tube. Review of Resident #27's Care Plan included a problem statement, dated 06/30/2025, that indicated the resident required tube feeding related to dysphagia and cerebral palsy, which placed the resident at risk for complications. Interventions directed staff to administer eternal feedings per physician's orders (initiated 06/30/2025) and provide water flushes per physician's orders (initiated 06/30/2025). Review of Resident #27's Physician Order Report, for the timeframe from 01/01/2025 through 07/02/2025, included an active order for enteral feeding formula at a rate of 65 milliliters (ml) per hour for 12 hours a day, from 5:00 P.M. to 5:00 A.M., with an order date of 06/03/2025. During an observation on 06/30/2025 at 10:14 A.M. in Resident #27's room, an IV pole utilized to attach a pump for eternal feedings for Resident #27 had brown spots of a sticky liquid on the legs of the pole. During an observation on 07/03/2025 at 9:06 A.M. in Resident #27's room, the IV pole appeared dirty with the lower legs of the pole containing brown spots of a sticky substance. During an observation on 07/07/2025 at 4:12 A.M. in Resident #27's room, the IV pole's legs were dirty. During an interview on 07/07/2025 at 1:18 P.M., the Assistant Director of Health Services (ADHS) observed the IV pole in Resident #27's room and stated the legs appeared to have tube feeding contents which had dripped down the pole. She stated that it was dirty and should be cleaned. During an interview on 07/11/2025 at 9:10 A.M., the Executive Director stated she expected the equipment to be cleaned appropriately. She stated that the facility did not have a cleaning schedule or a policy regarding cleaning multi-use equipment. This deficiency represents non-compliance investigated under Complaint Number OH00163512.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on record review, interview, and review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, the facility failed to ensure comprehensive Minimum Data Set (MDS) assessments were completed timely, which affected one (Resident #103) of 13 sampled residents. Specifically, the facility failed to ensure Resident #103's admission assessment was completed timely. The facility census was 50. Findings included:Review of Resident Face Sheet revealed the facility admitted Resident #103 on 06/23/2025 with a diagnosis of encephalopathy.Review of Resident #103's admission Minimum Data Set (MDS), with an admission Reference Date (ARD) of 06/30/2025, revealed the entry date (A1600), was entered as 06/23/2025. Per the MDS, the completion date (Z0500B), was dated 07/08/2025, 15 days after the entry date.During an interview on 07/08/2025 at 12:26 P.M., the MDS Coordinator stated that she had been trained that the admission MDS assessment was to be completed by the fourteenth day of the resident's stay, which would have been 07/06/2025 for Resident #103. She stated that the facility did not have a policy regarding MDS assessments and stated that she used the most recent version of the Resident Assessment Instrument (RAI) manual for completion date requirements.During an interview on 07/10/2025 at 3:00 P.M., the Assistant Director of Health Services (ADHS) stated she was unfamiliar with the MDS assessments completion date requirements. During an interview with the Executive Director on 07/11/2025 at 9:10 A.M., in regard to the timing of the completion of admission MDS assessments, the Executive Director stated staff should refer to the RAI manual to determine when admission MDSs should be completed. Review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2024, revealed the section titled, 5.2 Timeliness Criteria, included, In accordance with the requirements at 42 CFR [Code of Federal Regulations] S483.20(f)(1), (f)(2), and (f)(3), long-term care facilities participating in the Medicare and Medicaid programs must meet the following conditions, which included Completion Timing. The manual revealed, For the admission assessment, the MDS Completion Date (Z0500B) must be no later than 13 days after the Entry Date (A1600).

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. Based on record review, interview, and review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, the facility failed to ensure a quarterly Minimum Data Set (MDS) assessment was completed for one (Resident #11) of one resident reviewed as part of the resident assessment task. The facility census was 50.Findings included:Review of Resident Face Sheet indicated the facility originally admitted Resident #11 on 02/24/2021 and most recently readmitted the resident on 08/05/2024.Review of Resident #11's MDS 3.0 Resident Assessments revealed a quarterly MDS with an ARD of 01/14/2025 and an annual MDS with an ARD of 06/12/2025 were completed; however, there was no indication any additional MDS assessments were completed between 01/14/2025 and 06/12/2025. During an interview on 07/03/2025 at 1:02 P.M., the MDS Coordinator stated she was responsible for completing all MDS assessments. She stated quarterly MDS assessments should be completed every three months. The MDS Coordinator stated that Resident #11 was not out of the facility when their quarterly MDS was due. She stated Resident #11's should have had a quarterly MDS completed around 04/15/2025. The MDS Coordinator confirmed Resident #11 did not have a quarterly assessment completed in 04/2025, but she did not know why. She stated it was important to complete MDS assessments accurately and timely to get a clear picture of what was going on with a resident and what care they needed. During an interview on 07/03/2025 at 1:15 P.M., the Assistant Director of Health Services (ADHS) stated she was not involved in the completion or submission of MDS assessments. She stated she expected all MDS assessments to be completed on time.During an interview on 07/03/2025 at 1:20 P.M., the Executive Director (ED) stated she was not involved in the MDS process, but she expected MDS assessments to be completed within the timeframes required. Review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1.19.1, dated 10/2024 indicated, The ARD [Assessment Reference Date] of an assessment drives the due date of the next assessment. The next non-comprehensive assessment is due within 92 days after the ARD of the most recent OBRA [Omnibus Budget Reconciliation Act] assessment (ARD of previous OBRA assessment - Admission, Annual, Quarterly, Significant Change in Status, or Significant Correction assessment - + 92 calendar days). The manual further specified, The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure a tube feeding formula bag was labeled and dated for one (Resident #27) of two residents reviewed for tube feedings. The facility census was 50. Findings included:Review of Resident Face sheet revealed the facility originally admitted Resident #27 on 01/17/2025 and most recently admitted the resident on 05/28/2025. Resident #27 had a medical history that included diagnoses of cerebral palsy, pneumonitis due to inhalation of food or vomitus, gastrointestinal hemorrhage, encounter of attention to gastrostomy, gastrostomy malfunction, and dysphagia (difficulty swallowing). Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/25/2025, revealed Resident #27 had moderately impaired cognitive skills for daily decision-making and had short-term and long-term memory problems per a Staff Assessment for Mental Status (SAMS). The MDS indicated that the resident required substantial to maximal assistance with eating and indicated the resident had a feeding tube. The MDS indicated the resident received greater than 51% of their total calories via feeding tube. Review of Resident #27's Care Plan included a problem statement, dated 06/30/2025, that indicated the resident required tube feeding related to dysphagia and cerebral palsy, which placed the resident at risk for complications. Interventions directed staff to administer eternal feedings per physician's orders (initiated 06/30/2025) and to provide water flushes per physician's orders (initiated 06/30/2025). Review of Resident #27's Physician Order Report, for the timeframe from 01/01/2025 through 07/02/2025, included an active order for enteral feeding formula at a rate of 65 milliliters (ml) per hour for 12 hours a day, from 5:00 P.M. to 5:00 A.M., with an order date of 06/03/2025. An observation on 07/07/2025 at 4:12 A.M. revealed Resident #27 was in bed with tubing attached to an unlabeled bag of a tan-colored substance, which was running via a pump at 65 ml per hour. The tube feeding formula bag was not labeled with the resident's name, room number, date the feeding was hung, the time the bag was hung, the type/brand of the tube feeding formula, or the rate of infusion. During an observation on 07/07/2025 at 4:43 A.M., Licensed Practical Nurse (LPN) #1 entered the resident's room to flush Resident #27's feeding tube with water. After completing the water flush, LPN #1 removed the unlabeled bag of tube feeding formula and associated supplies and exited the resident's room. During a concurrent observation and interview on 07/07/2025 at 4:49 A.M., LPN #1 observed the tube feeding formula bag she removed from Resident #27's room and acknowledged it was not labeled. She stated she could not determine what type/brand of tube feeding had been provided to Resident #27 (because the bag was not labeled). She stated she knew that the tube feeding bag should be labeled to identify the ordered type/brand of tube feeding and when it was started. LPN #1 stated the tube feeding formula bag was hung by the nurse on day shift on 07/06/2025, and she had not noticed the bag was not labeled when she had been in to care for the resident during her shift. During an interview on 07/08/2025 at 7:45 A.M., LPN #2 stated she worked on day shift (7:00 A.M. to 7:00 P.M.) on 07/06/2025. She verified she hung and started Resident #27's tube feeding formula around 5:00 PM (on 07/06/2025). She said that because the pumps used in the facility and the original container of the ordered tube feeding formula were not compatible, she emptied the contents of the feeding formula into a disposable tube feeding bag before hanging it to be infused. She said she usually put the date and time the bag of feeding formula was hung on a sticker affixed to the bag. LPN #2 stated the stickers she used to label the tube feeding formula bags were known to fall off because they did not adhere well and could have fallen off. LPN #2 further stated she did not attempt to reinforce the sticker; she stated in the past, she had written the required information directly on the bag, but had not done that when she hung Resident #27's feeding formula on 07/06/2025. During an interview on 07/10/2025 at 2:44 P.M., the Assistant Director of Health Services (ADHS) stated feeding formula bags were to be labeled with the resident's name, room number, date and time the feeding was hung, the type/brand of the feeding formula, and the rate of infusion.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 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, interview, and facility document review the facility failed to ensure residents were free of significant medication errors for four (Residents #46, #103, #107, and #199) of four sampled residents reviewed for medication errors. The facility census was 50.Findings included: 1. Review of Resident Face Sheet revealed the facility admitted Resident #199 on 02/08/2025. The resident had a medical history that included diagnoses of cellulitis of the right and left lower limbs and methicillin-resistant Staphylococcus aureus (MRSA) infection. Review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/13/2025, revealed Resident #199 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. The MDS indicated Resident #199 did not reject care during the assessment's lookback period. The MDS revealed the resident had intravenous (IV) access on admission and while a resident. The MDS indicated Resident #199 admitted from a short-term general hospital. Review of Resident #199's Care Plan History, included a problem statement dated 02/19/2025, that indicated the resident required enhanced barrier precautions (EBP) during high-contact care related to the presence of a wound with dressing changes. Interventions directed staff to observe for and report any new or worsened signs/symptoms of infection. Review of Resident #199's Out-patient antibiotic therapy ([NAME])/Antibiotic Infusion orders, dated 02/07/2025, indicated the resident was to receive IV meropenem (an antibiotic) 1 gram (g) every eight hours and linezolid (an antibiotic), 600 milligrams (mg) by mouth every 12 hours, to complete 02/21/2025. The [NAME]/Antibiotic Infusion orders, indicated Resident #199 had bilateral leg wounds with a polymicrobial infection including MRSA infection. Review of Resident #199's View Prescription Order, received 02/09/2025 and started 02/10/2025, revealed a written physician's order for meropenem 1 g IV every eight hours, first administration time 12:00 A.M. Review of Resident #199's Physician Order Report, dated from 02/01/2025 through 07/02/2025, included an order for meropenem 1 g IV every eight hours at 12:00 A.M., 8:00 A.M., and 4:00 P.M., started on 02/10/2025. The Physician Order Report included an order for linezolid 600 mg by mouth every 12 hours for 14 days, started on 02/09/2025. Review of Resident #199's 02/2025 Medication Administration History revealed meropenem was not administered as scheduled on 02/10/2025 at 12:00 A.M. or 8:00 A.M. The Medication Administration History revealed staff documented that they administered the meropenem late on 02/10/2025 at 12:57 P.M. Further review revealed linezolid was not administered as scheduled on 02/09/2025 and 02/10/2025 from 7:00 A.M. to 11:00 A.M. The Medication Administration History revealed staff documented that they administered linezolid late on 02/10/2025 at 12:57 P.M. During an interview on 07/05/2025 at 12:37 P.M., Family Member #4, Resident #199's family member, stated Resident #199 was admitted to the facility to receive intravenous medications, but the antibiotics did not get started immediately after admission to the facility. During an interview on 07/08/2025 at 1:32 P.M., Licensed Practical Nurse (LPN) #5 indicated she could not recall transcribing the resident's admission orders and was unsure why Resident #199's antibiotic orders were not started immediately as ordered. During an interview on 07/08/2025 at 2:06 P.M., the Medical Director (MD) stated he was unaware that Resident #199's IV antibiotics were not started on admission but two days after admission. The MD stated he expected medications to be available to be administered as ordered and to be notified if medications could not be administered so the orders could be potentially modified or to provide further instructions, because when antibiotics were missed it resulted in a delay in treatment. During an interview on 07/09/2025 at 3:56 P.M., the Pharmacist revealed medication orders were received from the facility through an electronic medical record submission. The Pharmacist stated the pharmacy relied on the facility to transcribe all orders from a hospital discharge into the medical record. The Pharmacist stated the cut-off time for filling new admission orders for the standard delivery was 7:00 P.M.; however, the facility could contact the pharmacy to request medication be sent stat (immediately, at once) or drop shipment which would allow medication to be sent in as little as four hours. The Pharmacist stated anytime a nurse did not have a medication that was needed to be administered, they should contact the pharmacy to request a delivery time and request either a drop shipment or stat delivery of the item. The Pharmacist stated the pharmacy received the IV meropenem order on 02/09/2025 at 3:40 P.M., it was requested to be delivered stat, and it was received in the facility on 02/09/2025 at 10:00 P.M. During an interview on 07/10/2025 at 3:00 P.M., the Assistant Director of Health Services (ADHS) stated she expected residents to receive their medication when it was delivered and not have to wait until the next day. The

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, record review, and facility standard operating procedure review, the facility failed to ensure staff wore appropriate personal protective equipment (PPE) during close-contact activities for residents on enhanced barrier precautions (EBP), which affected one (Resident #27) of two residents reviewed for tube feeding and one (Resident #26) of two residents reviewed for non-pressure related skin conditions. The facility census was 50.Findings included: 1. Review of Resident Face Sheet revealed the facility admitted Resident #27 on 01/17/2025. The resident had a medical history that included diagnoses of cerebral palsy and dysphagia (difficulty swallowing). Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/25/2025, revealed Resident #27 had moderate impairment in cognitive skills for daily decision-making and had short-term and long-term memory problems per a Staff Assessment for Mental Status (SAMS). The MDS indicated that the resident required substantial to maximal assistance with eating. The MDS indicated the resident had a feeding tube and received greater than 51% of their total calories via feeding tube. Review of Resident #27's Care Plan, included a problem statement dated 06/30/2025, that indicated the resident required tube feeding related to dysphagia and cerebral palsy, which placed the resident at risk for complications. Interventions directed staff to administer eternal feedings per physician's orders (initiated 06/30/2025) and provide water flushes per physician's orders (initiated 06/30/2025). Review of Resident #27's Physician Order Report, for the timeframe from 01/01/2025 through 07/02/2025, included an active order dated 06/03/2025 for enteral feeding formula at a rate of 65 milliliters (ml) per hour for 12 hours a day, from 5:00 P.M. to 5:00 A.M. The Physician Order Report also included an order dated 05/28/2025 for staff to use EBP, wearing a gown and gloves at minimum during high contact activities. During an observation on 07/07/2025 at 4:43 A.M., License Practical Nurse (LPN) #1 entered Resident #27's resident's room, where there was signage posted on the door that indicated Resident #27 was on EBP. LPN #1 entered the room, carrying a pair of gloves and two partially filled glasses of water in hand. LPN #1 donned a pair of gloves and turned off Resident #27's tube feeding pump. LPN #1 placed a plunger barrel into Resident #27's feeding tube and allowed water to flow by gravity to flush the tube before capping off the tube. LPN #1 then removed the used syringe, the bag of unused water, and the bag of unused, tan-colored liquid from the feeding pump and took it from Resident #27's room. LPN #1 did not don a gown during the observation. During an interview on 07/07/2025 at 4:49 A.M., LPN #1 stated that she was aware Resident #27 was on EBP, and she had been taught to don a gown and gloves when completing care of the feeding tube. She stated she forgot to don a gown when she completed the care of Resident #27's feeding tube. During an interview on 07/07/2025 at 9:13 A.M., the Assistant Director of Health Services stated Resident #27 was on EBP and that she expected LPN #1 to don a gown and gloves when providing care of the feeding tube. During an interview on 07/11/2025 at 7:28 A.M., the Director of Health Services stated a resident on EBP had signage on their door indicating the resident was on EBP, and a PPE cart outside their room. She stated staff should wear standard EBP PPE, such as a gown, gloves, and goggles. 2. Review of Resident Face Sheet revealed the facility admitted Resident #26 on 06/07/2025. The resident had a medical history that included diagnoses of cellulitis of right and left lower extremities, open wound of the left and right lower extremities, methicillin resistant staphylococcus aureus (MRSA), and diabetic peripheral angiopathy without gangrene other bacterial infections of unspecified site. Review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/10/2025, revealed Resident #26 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. The MDS indicated the resident was at risk for developing pressure ulcers/injuries, and indicated the resident had moisture associated skin breakdown present. Review of Resident #26's Care Plan, included a problem statement dated 06/20/2025, that indicated the resident was at risk for skin breakdown related to cellulitis of the bilateral lower extremities. Interventions directed staff to provide treatments/preventative treatments as ordered (initiated 06/20/2025). Review of Resident #26's Physician Order Report, for the timeframe from 06/02/2025 through 07/02/2025, revealed an active order dated 06/30/2025 to cleanse open area to left lateral shin with normal saline, pat dry, apply a dressing, and cover with rolled gauze, then compression wrap daily for wound management. The Physician Order Report also revealed an order dated 06/12/2025 that indicated staff were to use EBP, wearing a gown and gloves at minimum during high-contact activities. During an observation on 07/03/2025 at 1:35 P.M., Registered Nurse (RN) #3 was wearing gloves and provided wound care to Resident #26's left leg. RN #3 did not don a gown