STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366424	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein New Albany	6690 Liberation Way New Albany, OH 43054

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 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** Based on record review, staff interview, and policy review, the facility failed to timely assess, stage and provide treatment to a pressure ulcer that was identified on admission for a resident. Actual harm occurred on 12/30/25 when Resident #5's pressure ulcer had a documented decline after there was no documented wound assessment or measurements completed by the facility for 20 days. The stage of the pressure ulcer was not documented on admission and the ulcer became larger in size and was unstageable. This affected one resident (Resident # 5) of four residents reviewed for pressure ulcers The facility census was 60.Findings include:Record review revealed Resident # 5's was admitted on [DATE] with diagnoses including end stage renal disease on hemodialysis, uterine cancer, Diabetes Mellitus Type II, obstructive uropathy, depression and retroperitoneal hematoma. Review of Resident # 5's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was cognitively intact. She required assistance from staff with transfers, toileting hygiene, bathing and dressing and had a pressure ulcer. Review of Resident # 5's readmission screen dated 12/10/25 revealed she had a pressure ulcer to her sacrum measuring 1.5 centimeters (cm) in width by two cm in length. There was no documented depth, stage, or description of the pressure ulcer. Review of Resident # 5's weekly skin observations dated 12/21/25 to 02/14/26 revealed no documented pressure ulcer, pressure ulcer description, or pressure ulcer measurements. Review of the skin observation dated 12/27/25 revealed Registered Nurse (RN) #118 documented the pressure ulcer as ongoing and every day wound care on the coccyx continues on buttocks with drain. Wound getting bigger and worse. Resident #5's medical record had no measurements of the of the pressure ulcer and no documentation the physician was notified of the worsening condition of the wound. Review of physician's orders for December 2025 revealed no wound care orders for sacral wound from 12/10/25 to 12/29/25 except for house barrier cream every shift and after each incontinent episode dated 12/12/24. Review of Resident # 5's wound evaluation by Wound Physician (WP #351) dated 12/30/25 revealed an unstageable pressure ulcer (not stageable due to coverage of wound bed by slough and/or eschar) on the sacrum measuring 4.8 cm in width by 14.5 cm in length by 0.3 cm deep with necrotic (dead, non-viable) tissue and slough (yellow tissue with dead cells, fibrin and bacteria). Wound care treatment was ordered for calcium alginate once daily. Review of Resident # 5's physician's orders revealed a wound care order dated 12/30/25 for a sacral wound to cleanse wound with wound cleanser or soap and water. Pat dry. Apply calcium alginate and cover with a clean dry dressing daily, every day on day shift, and as needed until resolved. Review of Resident #5's wound physician weekly wound evaluations for 01/06/26 and 01/07/26 revealed the physician visits were rescheduled due to Resident #5 being at dialysis. Review of Resident #5's weekly wound evaluation visit for 01/13/26 by WP #351 revealed the physician signed off on Resident #5's care as resident goes to dialysis during his weekly visits. Review of Resident # 5's progress note dated 01/14/26 revealed wound rounds were discontinued with the wound doctor due to the resident's dialysis schedule. The facility was to continue to follow and treat skin areas as planned and follow up with the wound doctor as needed. Review of skin observation dated 01/17/26 revealed RN # 118 documented the ulcer was ongoing and daily wound care on the coccyx and on the buttocks continues. Wound is bigger, drains and with bad smells. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366424	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #5's medical record had no measurements of the wound for this observation and did not document the physician was notified of the worsening condition of the wound. Reviews of the January 2026 and February 2026 physician orders revealed there had been no change to the wound care treatment for Resident #5's sacral wound. During an interview on 02/25/26 at 3:36 P.M., the Director of Nursing (DON) stated the Resident #5 was not able to be followed by the wound doctor due to wound round days and the resident's dialysis schedule. The DON stated her expectation would be that nursing would continue to assess and measure the wound and follow up with the physician as needed for Resident # 5's wound care. The DON confirmed Resident # 5's weekly skin observations had no wound assessments, or measurements completed from 12/21/25 to 02/14/26. She also confirmed Resident #5 had a documented worsening of the sacral wound on 01/17/26 by RN #118 and the physician had not been contacted. Resident #5 continued with the same wound care order since 12/30/25 despite the documented decline in the wound. Review of facility policy titled Skin Care Management Procedure, dated 12/09/22, revealed with each dressing change or at least weekly at minimum, documentation should include the date wound observed; location and staging; size, depth; and the presence, location and extent of any undermining or tunneling/sinus tract; exudates, if present; pain; wound bed color and type of tissue/character including evidence of healing or necrosis and description on wound edges as appropriate. It also states if pressure ulcer fails to show improvement within 2-4 weeks, the area and the residents over all condition should be reassessed. Reevaluation of the treatment plan should occur, and the decision made to continue or make changes to the current interventions.

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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 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. Based on observations, staff interviews, and facility policy review, the facility failed to store and date food appropriately. This had the potential to affect 36 (Residents #55, #70, #23, #25, #50, #11, #28, #1, #68, #41, #61, #69, #12, #37, #4, #18, #43, #6, #16, #59, #45, #9, #5, #29, #22, #36, #2, #20, #10, #40, #13, #39, #53, #17, #54, and #42) of 48 residents reviewed for food safety. Also, the facility failed to ensure hair restraints were in place when required. This had the potential to affect 12 (Residents #8, #38, #52, #31, #58, #56, #35, #60, #62, #67, #46, and #21) of 12 residents in house one. Finally, the facility failed to ensure all food preparation tools and equipment were fully cleaned and sanitized prior to use. This had the potential to affect four (Residents #67, #52, #12, and #59) of four residents who were identified as requiring altered textured diets in house one and house three. The census was 60.Findings Include:Observation on 02/23/26 at 8:18 A.M. revealed in house three refrigerator, the following items were not stored and/or dated correctly: glass pan of gelatin covered in plastic wrap that had no date on it; a zippered plastic bag of bacon, which was not it's original packaging, and had no date on it; and a zippered plastic bag of salami, which was not in it's original packaging and had no date on it.Interview with Certified Nursing Aide (CNA) #133 on 02/23/26 at 8:24 A.M. confirmed the above items were opened and undated. She confirmed there should be a date as to when the food item was placed in the refrigerator or a date as to when the food should be discarded; she confirmed none of the food listed above had either date.Observation on 02/23/26 at 8:27 A.M. revealed in house two refrigerators, the following items were not stored and/or dated correctly: a gallon sized zippered plastic bag with cooked rice and sauce that had no date on it; a gallon sized zippered plastic bag with a cooked turkey leg that had not date on it; an opened package of one uncooked turkey leg, covered with aluminum foil, that had no date on it; and a styrofoam plate with cooked taco meat and vegetables, covered with aluminum foil, and had not date on it. Interview with CNA #161 on 02/23/26 at 8:37 A.M. confirmed the above listed items were opened, in the kitchen refrigerator, and had no dates on them. She stated all the food that was identified was food brought in by staff for themselves, but confirmed they all should have dates on them regardless.Observation on 02/23/26 at 8:43 A.M. revealed in house four refrigerators, the following items were not stored and/or dated correctly: a zippered plastic bag of multiple small dough covered food items (actual food was unknown) with no date on the bag; and a bowl of cooked tomato soup covered with plastic wrap with no date on it. Interview with Diet Technician #186 on 02/23/26 at 8:48 A.M. confirmed the above listed items were out of their original packaging, cooked/prepared, and not dated when placed in the kitchen refrigerator. He confirmed there should be dates on any left overs placed back in the refrigerator.Review of facility Food Labeling and Dating policy, dated 06/01/08, revealed if food is portioned for meal service, it is covered and labeled and dated. Review of facility Food Storage Policy, dated 10/01/09, revealed once food is removed from its original package, it is stored in a clean, covered, approved container, identified by name, and dated with month, day and year. Observation on 02/25/26 from 11:15 A.M. to 11:25 A.M. found Neighborhood Concierge (NC) #127 had a hair net on top of her head, but her long hair, that went to her waist, was hanging out unrestrained. Interview with Dietitian #350 on 02/25/26 at 11:25 A.M. confirmed NC #127's hair should have been fully restrained. Dietitian #350 reminder her that she needed to have all of her hair restrained; she put her long hair down the back side of her shirt at that time.Observation on 02/25/26 at 11:50 A.M. revealed CNA #160 finished blending chicken in the food processor. After pouring the blended chicken on to a plate, she went to the sink and rinsed the canister with warm water to remove the excess chicken. After doing this, she placed the canister back onto the blender, and was starting to pour broccoli into the canister. She had not cleaned the canister with soap and water and/or sanitizer prior to using it again. She was stopped by the surveyor at that point.Interview with CNA #160 on 02/25/26 at 11:51 A.M. confirmed she had not cleaned the canister with soap/water and/or sanitizer prior to (continued on next page)

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	366424	A. Building B. Wing	02/26/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	beginning to use it again. She stated she normally would wash it in the dishwasher prior to using it again, but she was in a hurry to get everything completed.Observation on 02/25/26 at 12:40 P.M. revealed NC #127 finished blending chicken in the food processor. After pouring the blended chicken into a one portion sized bowl, she went to the sink and rinsed the canister with warm water and her gloved hand to remove the excess chicken. After doing this, she placed the canister back onto the blender, and was starting to pour broccoli into the canister. She had not cleaned the canister with soap and water and/or sanitizer prior to using it again. She was stopped by the surveyor at that point.Interview with NC #127 on 02/25/26 at 12:40 P.M. confirmed initially stated she had fully cleaned the canister prior to using it again. When asked where the soap and cloth was that she used at the sink, she then stated she did not and went on to clean the canister appropriately with soap and water.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review, interview, and facility policy review, the facility failed to have a justified diagnosis for the use of a psychiatric medication. This affected one resident, (Resident #55), out of five residents reviewed for unnecessary medication. The facility census was 60.Findings include: Review of the medical record for Resident #55 revealed an admission date of 01/15/25 with diagnoses including but not limited to, anxiety (01/15/25), insomnia (01/15/25), major depressive disorder (03/20/25), unspecified dementia (03/20/25), and unspecified mood affective disorder (03/20/25). Review of Resident #55's physician orders on 02/24/26 revealed an order for Olanzapine (antipsychotic) five milligrams (mg) one tablet by mouth at hour of sleep for schizophrenia beginning 12/16/25, and Olanzapine 2.6 mg one tablet by mouth every day for schizophrenia beginning 12/17/25. Review of annual Minimum Data Set (MDS) 3.0 section C, dated 01/26/26, on 02/24/26 revealed a Brief Interview for Mental Status (BIMS) of nine. Further review under section I revealed no diagnosis of schizophrenia. Review of PASRR completed 04/03/25 on 02/24/26 revealed no diagnosis of schizophrenia. Interview with Director of Nursing (DON) on 02/25/26 at 12:10 P.M. confirmed Resident #55 did not have a diagnosis in the record of schizophrenia but was receiving medication for it. Interview with the Administrator on 02/25/26 at 2:25 P.M. revealed the diagnosis of schizophrenia was identified after Resident #55's admission at the behavioral health hospital 03/14/25. However, further interview revealed the paperwork the facility obtained from the behavioral health hospital post discharge confirmed there was no diagnosis of schizophrenia. Review of the facility's Psychotropic Medication Management Policy dated 03/05/25 revealed an unnecessary drug is any drug when used without adequate indications for use. Further review of the policy also revealed when psychotropic medications are ordered or increased the facility will ensure a specific diagnosis is documented in the medical record.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, pharmacy recommendation review, and interview, the facility failed to address pharmacy recommendations. This affected one resident (Resident #55) out of five reviewed for unnecessary medications. The facility census was 60.Findings include: Review of Resident #55's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis, anxiety disorder, dementia, depression and hypertensive heart disease. Review of pharmacy recommendations for Resident #55 on revealed a pharmacy recommendation on 03/14/25 that stated the resident was admitted for m the hospital on [DATE]. The hospital records indicate the resident should be receiving Norvasc (used for high blood pressure) five milligrams (mg) every day. Please clarify the status of this medication. The recommendation did not have a response from the prescriber and had no documented followed up by the facility. Review of pharmacy recommendations for Resident #55 on revealed a pharmacy recommendation on 06/16/25 that stated the resident had order for Hydroxyz (Hydroxyzine) HCL (antihistamine) tablet 50 mg one tablet by mouth every six hours as needed without a stop date which was started on 04/05/25. The recommendation was to either discontinue the medication, add a stop date or update to scheduled dosing. The recommendation did not have a response from the prescriber and had no documented followed up by the facility. Review of pharmacy recommendations for Resident #55 on revealed a pharmacy recommendation on 10/16/25, that stated the resident had an order for Donepezil tablet (used for dementia) five mg one tablet by mouth daily for dementia. The recommendation documented he manufacturer's recommendations suggest Start five mg at bedtime for four to six weeks then increase to 10 mg at bedtime. Unless clinically contraindicated at tis time could we please consider to increase the dose to 10 mg at bedtime or a dose preferred by prescriber. The recommendation did not have a response from the prescriber and had no documented followed up by the facility. Review of pharmacy recommendations for Resident #55 on revealed a pharmacy recommendation on12/18/25 that stated the resident had an order for Donepezil tablet five mg one tablet by mouth daily for dementia. The recommendation documented he manufacturer's recommendations suggest Start five mg at bedtime for four to six weeks then increase to 10 mg at bedtime. Unless clinically contraindicated at tis time could we please consider to increase the dose to 10 mg at bedtime or a dose preferred by prescriber. The recommendation did not have a response from the prescriber and had no documented followed up by the facility. Interview with Director of Nursing (DON) on 02/25/26 at 2:15 P.M. confirmed the above listed pharmacy recommendations were not did not have a response from the prescriber and should have been followed up on.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to provide parameters for as needed pain medications. This affected one (Resident #39) of five residents reviewed for unnecessary medications. The census was 60.Findings Include:Resident #39 was admitted to the facility on [DATE]. His diagnoses were acute osteomyelitis, direct infection of right ankle, hypertensive heart and chronic kidney disease, Type II Diabetes, atrial fibrillation, sleep apnea, major depressive disorder, acute kidney failure, hyperlipidemia, hypertension, and pressure ulcer of sacral region (stage IV). Review of his minimum data set (MDS) assessment, dated 01/19/26, revealed he had a mild cognitive impairment. Review of Resident #39's physician orders found the following as needed pain medications orders: Oxycodone HCl (opioid) five milligrams (mg), one tablet every six hours as needed for pain; Oxycodone HCl five mg, two tablets every six hours as needed for pain; Acetaminophen (analgesic) 325 mg, give 650 mg every four hours as needed for pain/fever; and Morphine sulfate (opioid) 100 mg/5 milliliters (mL), 0.25 mL every four hours as needed for pain and shortness of breath. For all three as needed pain medication orders, there were no parameters documented as to when each medication should be administered.Review of Resident #39's January 2026 medication administration record (MAR), revealed the following medications were administrated and the pain levels associated with the pain medication: Acetaminophen was administered twice for pain levels six and seven; Oxycodone five mg, one tablet was administered nine times for pain levels one to eight; and Oxycodone five mg, two tablets was administered six times for pain levels between six to eight. Review of Resident #39's February 2026 MAR, revealed the following medications were administered and the pain levels associated with the pain medication: Morphine was administered 27 times for pain levels between 0 and 10, including two administrations for pain levels of zero; Oxycodone five mg, one tablet was administered five times for pain levels five to nine; and Oxycodone five mg, two tablets was administered 14 times for pain levels between four to ten. Interview with Licensed Practical Nurse (LPN) #190 on 02/26/26 at 11:50 A.M. confirmed there should be parameters on all as needed pain medications. Typically they will administer high strength pain medication, like Oxycodone, for pain levels that are six or higher, and they will administer a lower strength pain medication, like Acetaminophen, for pain levels one to five. She also confirmed as needed pain medication should not be administered for a pain level of zero.Interview with Director of Nursing (DON) on 02/26/26 at 11:52 A.M. confirmed as needed pain medication should be administered as ordered. She stated the nurses can use their judgement or the resident (if cognitively intact) can tell the nurse which medication they want when they have pain. But, she confirmed there are typically parameters for as needed pain medication.Review of facility Pain Management policy, dated 12/28/21, revealed after consultation with the physician and resident (or resident representative), medication and dosage schedules will be established based on the characteristics of the resident's pain.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, medical record review, staff interview, and facility policy review, the facility failed to ensure altered texture diets were prepared in a correct and safe manner. This affected one (Resident #67) of three residents reviewed for altered texture diets. The census was 60.Findings Include:Observation on 02/25/26 from 12:20 P.M. to 12:35 P.M. revealed Neighborhood Concierge (NC) #127 blended cooked chicken in a normal blender; not a food processor. NC #127 blended the chicken for about five to six minutes and then poured the contents into one portion bowl. NC #127 stated the blended chicken was to the standard she wanted it for pureed chicken. There were clear chunks and whole pieces of chicken observed in the bowl. The chicken was tasted by the surveyor and Dietitian #350 tasted the blended chicken it was confirmed the chicken was not to their standard for a pureed consistency. aResident #67 was admitted to the facility on [DATE]. Her diagnoses were encephalopathy, dysphagia, unspecified protein calorie malnutrition, hypertensive heart disease, hyperlipidemia, vitamin D deficiency, thrombocytosis, anxiety disorder, restlessness and agitation, arthropathy, and sleep disorder. Review of her minimum data set (MDS) assessment, dated 02/02/26, revealed she had a severe cognitive impairment.Review of Resident #67 current dietary orders found that she had a puree texture diet order.Interview with Dietitian #350 on 02/25/26 at 12:35 P.M. confirmed the blended chicken should have been blended more; it was not to the standard and safety the facility wanted for puree texture food for the residents.Review of facility Neighborhood Diets Policy, dated 01/01/09, revealed a pureed texture diet was defined/described as a regular diet with texture altered to accommodate those with difficulty swallowing and/or chewing. Texture varies from thin (applesauce) to thick (mashed potatoes). Bread or bread substitute is incorporated into recipes to meet nutritional guidelines.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to display proper Enhanced Barrier Precaution (EBP) signage. This affected two residents (Resident #23 and Resident #70). Furthermore, the facility failed to follow proper infection control procedures during dressing change for #39. This affected three residents of five reviewed for infection control. The facility census was 60.Findings include: 1.Review of Resident #23's medical record revealed an admission date of 01/06/26 with diagnoses that included but were not limited to hypertension, diabetes, and hyperlipidemia. Review of Resident #23's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview of mental status score of 15 indicating the resident was cognitively intact. Further review of the MDS revealed the resident had a multidrug resistant organism and isolation/quarantine for an active infectious disease. Observation of Resident #23 on 02/23/26 at 11:25 A.M. revealed an EBP tote outside of their room. There was no signage on the residents' door identifying them as being on EBP or further precautions. 2.Review of Resident #70's medical record revealed an admission date of 01/14/26 with diagnoses that included but were not limited to coronary artery disease, hypertension, and diabetes. Review of Resident #70's Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview of mental status score of 14 indicating the resident was cognitively intact. Further review of the MDS also identified the resident as being on oxygen and intravenous (IV) medications. Observation of Resident #70 on 02/23/26 at 11:25 A.M. revealed an EBP tote outside of their room with no signage identifying the resident as being on EBP or further precautions. Review of the facility's list of residents on EBP on 02/23/26, provided by the facility on 02/23/26, revealed Resident #23 and Resident #70 were on EBP. Interview with the Director of Nursing (DON) on 02/24/26 at 8:27 A.M. confirmed both Resident #23 and Resident #70 were on EBP and did not have signage on their door indicating EBP precautions were required on 02/23/26. The DON confirmed the signage should have been on the room door for both Resident #23 and Resident #70. Review of the facility's Infection Prevention and Control Program revised 11/05/21, on 02/24/26, revealed part of the facility's practice to prevent and control onset and spread infection is to use standard and transmission-based precautions. Further review of the policy revealed the facility was to implement practices consistent with accepted standards to help reduce the spread of infections. 3. Review of Resident # 39's medical record revealed an admission date of 01/15/26 with diagnoses that included but were not limited to osteomyelitis of the right ankle and foot, Diabetes Mellitus Type II with neuropathy, acquired absence of left leg below the knee and stage four sacral pressure ulcer. (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	Review of Resident # 39's Minimum Data Set MDS dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11. He required assistance from staff with transfers, toileting hygiene and dressing. Review of Resident # 39's physicians orders dated February 2026 revealed the following sacral wound care order: cleanse wound with normal saline or wound cleanser. Pat dry. Apply calcium alginate and cover with a clean dry dressing daily every day shift and as needed. Observation on 02/25/26 at 8:35 A.M. of Resident # 39's sacral wound care with Licensed Practical Nurse (LPN) # 179 revealed LPN # 179 gathered a calcium alginate dressing, wound cleanser and a bordered gauze and placed them on the resident's bedside table. LPN # 179 and Certified Nursing Assistant (CNA) # 124 sanitized their hands and applied gowns and gloves. With gloved hands LPN # 179 removed the soiled dressing from Resident # 39's sacrum and carried it to the bathroom to dispose of it. He returned carrying a small trash can from the bathroom which he placed on the floor bedside him. LPN # 179 then proceeded with wound treatment by spraying the wound with wound cleanser, he applied the calcium alginate dressing and then applied a clean dry dressing. Interview on 02/25/26 at 8:47 A.M. with LPN # 179 confirmed while completing Resident # 39's sacral wound treatment he did not wash his hands or change his gloves after removing the soiled dressing and touching a trash can. He also verified he did not dry the wound area per order prior to applying calcium alginate and a clean dry dressing to Resident #39's sacral wound.