STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445017	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Place at Maryville	936 Epworth Road Maryville, TN 37804

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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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on facility policy review, observations, and interviews, the facility failed to maintain safe food storage in the dietary department and failed to maintain fully operational equipment which had the potential to affect 115 residents. The findings include: Review of the facility policy titled, Sanitation and Food Safety, Labeling and Dating undated, revealed .Leftovers and open foods shall be clearly labeled .With date food item is to be discarded .Food items to be labeled and dated include items prepared in house and food items that are opened and stored for later use .7 day shelf life including date of preparation .label includes .Name of food item .discard date (to be discarded at end of 7th day .30 day shelf life, usually applies to items that are shelf stable until opened .label includes .name of food item .discard date .(i.e.[example] opened 4/30 .discard 5/30) .Discard date cannot exceed use by date stamped on product by manufacturer . During observations of the dietary department dry storage space on 1/12/2026 between 11:05 AM and 11:35 AM revealed the following: 1. One plastic container half full labeled toasted oats undated and available for resident use. 2. One plastic container half full of dry cereal labeled with a use by date of 12/25/2025 and available for resident use. 3. 12, 12.7 ounce packs of flour tortilla shells with a use by date of 8/7/2025 and available for resident use. 4. 5, 16 ounce bags of vanilla wafers with a use by date of 11/11/2025 and available for resident use. 5. 1 sealed half-gallon freezer bag half full with no label identifying the content of the bag or the expiration date and available for resident use. 6. A plastic container half full of coconut flakes with a use by date of 8/3/2025 and available for resident use. 7. A plastic container of breading flakes with approximately a half cup remaining, labeled with a use by date of 3/18/2025 and available for resident use. 8. A plastic container half full of dry macaroni noodles, dated 9/15/2025, no open date, no use by date, no label identifying product and available for resident use. Further observation of the walk-in refrigerator on 1/12/2026 between 11:45 AM and 11:50 AM revealed: 1. A half pan of shredded Parmesan cheese with an open date of 12/30/2025, no use by date, and available for resident use. 2. A 1-gallon freezer bag which contained a half block of American Cheese with no label or use by date and available for resident use. During an observation and interview on 1/12/2026 at 11:53 AM in the food preparation areas revealed the facility's deep fryer was not operational. The Dietary Manager stated the deep fryer had been out of use since October 2025, and she was uncertain when it would be repaired or replaced. Continued observations revealed a reach in refrigerator that was not operational. The Dietary Manager stated the reach in refrigerator had been out of service for several months and she was uncertain when the reach in refrigerator would be replaced or repaired due to manufacturer parts availability issues.During an interview on 1/12/2025 at 11:56 AM, the Dietary Manager confirmed foods observed and noted above had been stored improperly and was in violation of the facility policy.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interviews, the facility failed to obtain consent for administration of psychotropic medications for 4 residents (Resident #11, #92, #4 and #77) of 5 residents reviewed for unnecessary medications.The findings include: Review of the facility policy titled, Psychotropic Drugs Usage, undated, revealed .Any resident receiving psychotropic medication will have a signed informed consent for the use of the medication .Informed consents will be initiated upon the start of the medication usage . Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Dementia, Panic Disorder, and Major Depressive Disorder. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 scored a 00 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment and received antipsychotic medication. Review of the Physician's Orders for Resident #11dated 1/12/2026, revealed an order for Quetiapine (a medication used to treat psychotic disorders) 25 mg (milligram) by mouth once daily at bedtime. Review of the Medication Administration Record (MAR) dated 1/1/2026 to 1/14/2026, revealed Resident #11 received Quetiapine 25 mg daily. Review of the medical record revealed no consent form for the use of Quetiapine for Resident #11. Review of the Physician's Orders for Resident #11 dated 1/12/2026, revealed an order for Olanzapine (a medication used to treat psychotic disorder) 5 mg tablet by mouth twice daily. Review of the MAR for Resident #11 dated 1/1/2026 to 1/14/2026, revealed the resident received Olanzapine 5 mg daily. Review of the medical record revealed no consent form for the use of Olanzapine for Resident #11. Review of the medical record revealed Resident #92 was admitted to the facility on [DATE] with diagnoses including Vascular Dementia, Cognitive Communication Deficit, and Lack of Coordination. Review of a quarterly MDS assessment dated [DATE], revealed Resident #92 scored a 6 on the BIMS assessment which indicated the resident had severe cognitive impairment and received antipsychotic medication. Review of the Physician's Orders for Resident #92 dated 9/19/2025, revealed an order for Quetiapine 12.5 mg by mouth once daily at bedtime. Review of the MAR for Resident #92 dated 1/1/2026 to 1/14/2026, revealed the resident received Quetiapine 12.5 mg daily. Review of the medical record revealed no consent form for the use of Quetiapine for Resident #92. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including Dementia with Behavioral Disturbance and Depression. Review of a significant change MDS assessment dated [DATE], revealed Resident #4 scored a 00 on the BIMS assessment which indicated the resident had severe cognitive impairment and received antipsychotic medication. Review of the Physician's Orders for Resident #4 dated 11/26/2025, revealed an order for Olanzapine 5 mg by mouth two times daily. Review of the MAR for Resident #4 dated 1/1/2026 - 1/14/2026, revealed the resident received Olanzapine 5 mg twice daily. Review of the medical record revealed no consent form for the use of Olanzapine for Resident #4. Review of the medical record revealed Resident #77 was admitted to the facility on [DATE] with diagnoses including Anxiety Disorder, Bipolar Disorder, Major Depressive Disorder, Psychosis, and Mood Affective Disorder. Review of the annual MDS assessment dated [DATE], revealed Resident #77 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact and received antianxiety medication. Review of the Physician Order's for Resident #77 dated 3/5/2025, revealed an order for Alprazolam (a medication used to treat Anxiety) 0.5 mg two times daily. Review of the MAR for Resident #77 dated 1/1/2026 to 1/14/2026, revealed the resident received Alprazolam 0.5 mg two times daily. Review of the medical record revealed no consent form for the use of Alprazolam for Resident #77. During an interview on 1/14/2026 at 1:49 PM, the Assistant Director of Nursing confirmed there were no psychotropic medication consent forms in place for Residents #11, #92, #4, and #77.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Long- Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 review, medical record review, and interviews, the facility failed to ensure Minimum Data Sets (MDS) assessments were accurate for 2 residents (Resident #6 and Resident #84) of 26 residents reviewed for MDS assessments.The findings include: Review of the Long- Term Care Facility RAI 3.0 User's Manual Version 1.20.1, dated 10/2025, revealed .Health-related Quality of Life .residents covered by Level II PASRR [Pre-admission Screening and Resident Review] process may require certain care and services provided by the nursing home .Steps for Assessment .Code .1, yes .if PASRR Level II screening determined that the resident has a serious mental illness .Active Diagnosis in the Last 7 Days .Check all that apply .I0600 .Heart Failure .ACTIVE DIAGNOSES Physician- documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status .medical treatments, nursing monitoring, or risk of death during the 7- day look- back period .Check off each active disease . Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including Post-Traumatic Stress Disorder, Dementia, Bipolar Disorder, and Intellectual Disabilities. Review of a Notice of PASRR (Pre-admission Screening and Resident Review) Level II Outcome dated 3/26/2021, revealed .The Individual [Resident #6] meets criteria for having a diagnosis of .Intellectual disability .Serious mental illness . Review of an annual MDS (Minimum Data Set) assessment dated [DATE], revealed .is resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition .No . Review of a Nurse Practitioner progress note for Resident #6 dated 12/18/2025, revealed .resident has a history of major depressive disorder, bipolar disorder, anxiety disorder, dementia, and trauma/stressor related disorder diagnoses, and intellectual disability . During an interview on 1/14/2026 at 9:15 AM Licensed Practical Nurse MDS Coordinator confirmed Resident #6 had a level II PASRR and the annual MDS assessment dated [DATE] was inaccurate. Review of the medical record revealed Resident #84 admitted to the facility on [DATE] with diagnoses including Acute on Chronic Diastolic Congestive Heart Failure and Pulmonary Hypertension. Review of a Medication Administration Record (MAR) for Resident #84 dated 11/20/2025 through 11/30/2025, revealed the resident had received Furosemide (Lasix) (a medication used to treat fluid retention) 80 mg (milligram) one tablet two times a day from 11/20/2025 through 11/30/2025. Further review revealed the resident had received metolazone (a medication used to treat fluid retention) 5 mg one tablet by mouth in the morning from 11/21/2025 through 11/30/2025. Continued review revealed the resident had received metoprolol tartrate (a medication used to treat high blood pressure) 50 mg one tablet by mouth two times a day from 11/20/2025 through 11/30/2025. Review of the Nurse Practitioner progress note for Resident #84 dated 11/21/2025, revealed .Past Medical History .Diastolic Congestive Heart Failure XXX[AGE] year-old .history of diastolic congestive heart failure .recent hospitalization November 14th through 19th [11/14/2025 through (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/19/2025] .for acute diastolic congestive heart failure exacerbation .Assessment & [and] Plan .Diastolic congestive heart failure .continue diuresis with Lasix 80 mg twice daily and metolazone .Continue metoprolol . Review of an admission MDS assessment dated [DATE], revealed Resident #84 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Further review revealed Heart Failure was not checked to reflect the active diagnosis for Resident #84 and the resident received Diuretics (medications that reduce fluid retention). Review of an Order Summary Report for Resident #84 dated 1/14/2026, revealed the following Physician's orders including Furosemide 80 mg give one tablet by mouth two times a day (start date 11/20/2025), Metolazone 5 mg give one tablet by mouth in the morning (start date 11/21/2025), and Metoprolol Tartrate 50 mg give one tablet by mouth two times a day (start date 11/20/2025). During a medical record review and interview on 1/14/2026 at 1:33 PM, Registered Nurse (RN) MDS Coordinator reviewed the Nurse Practitioner progress note dated 11/21/2025, the Order Summary report dated 1/14/2026, the MAR dated 11/20/2025 through 11/30/2025, and the admission MDS assessment dated [DATE] for Resident #84. The RN MDS Coordinator confirmed the admission MDS assessment for Resident #84 dated 11/27/2025 was inaccurate and did not reflect Resident #84's active diagnosis of Heart Failure.

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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** Based on facility policy review, medical record review, and interviews, the facility failed to develop a comprehensive care plan for 2 residents (Resident #6 and Resident #84) of 26 residents reviewed for care planning. The findings include: Review of the facility's policy titled, Baseline Care Plan Assessment/Comprehensive Care Plans, revised 3/23/2021, revealed .The Comprehensive Care Plan will .expand on the resident's risk, goals and interventions using the 'person centered' Plan of Care approach for each resident that includes measurable objectives and time tables to meet the resident's medical, nursing, physical functioning, mental, and psychosocial needs .The Comprehensive Care Plan will be finalized within 7 days of completion of the Full Comprehensive MDS [Minimum Data Sets] assessments .the Comprehensive Care Plan will include any Specialized Services or Specialized Rehab Services recommended to be provided as a result of any Pre-admission screening and Resident Review (PASARR) that may have been completed .The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum .The facility may need to review that care plans more often based on changes in the resident's condition and/or newly developed health/ psycho-social issues .The MDS staff will attend the Morning .meetings where in-depth review of the 24 Hour Report(s) since the prior Morning .meeting are reviewed and discussed as well as new or changed orders, new admissions, readmissions, falls and other pertinent circumstances .They will then see that the care plans for these residents are revised and updated as necessary . Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including Post-Traumatic Stress Disorder, Dementia, Bipolar Disorder, and Intellectual Disabilities. Review of a Notice of PASRR (Pre-admission Screening and Resident Review) Level II Outcome dated 3/26/2021, revealed .The Individual [Resident #6] meets criteria for having a diagnosis of .Intellectual disability . Serious mental illness . Review of the comprehensive care plan revised 6/17/2025, revealed Resident #6's Level II PASRR was not addressed. During an interview on 1/14/2026 at 9:15 AM, the Licensed Practical Nurse MDS Coordinator confirmed the comprehensive care plan for Resident #6 did not reflect the residents Level II PASRR status. Review of the medical record revealed Resident #84 was admitted to the facility on [DATE] with diagnoses including Acute on Chronic Diastolic Congestive Heart Failure and Pulmonary Hypertension. Review of a Medication Administration Record (MAR) for Resident #84 dated 11/20/2025 through 11/30/2025, revealed the resident had received Furosemide (Lasix) (a medication used to treat fluid retention) 80 mg (milligram) one tablet two times a day from 11/20/2025 through 11/30/2025. Further review revealed the resident had received metolazone (a medication used to treat fluid retention) 5 mg one tablet by mouth in the morning from11/21/2025 through 11/30/2025. Continued review (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed the resident had received metoprolol tartrate (a medication used to treat high blood pressure) 50 mg one tablet by mouth two times a day from 11/20/2025 through 11/30/2025. Review of the Nurse Practitioner progress note for Resident #84 dated 11/21/2025, revealed XXX[AGE] year-old .history of diastolic congestive heart failure .recent hospitalization November 14th through 19th [11/14/2025 through 11/19/2025] .for acute diastolic congestive heart failure exacerbation .Assessment & [and] Plan .Diastolic congestive heart failure .continue diuresis with Lasix 80 mg twice daily and metolazone .Continue metoprolol . Review of the comprehensive care plan for Resident #84 revised 12/2/2025, revealed the resident's active diagnosis of Heart Failure was not outlined or addressed on the comprehensive care plan. During an interview on 1/14/2026 at 1:33 PM, the Registered Nurse (RN) MDS Coordinator confirmed the comprehensive care plan revised 12/2/2025 for Resident #84 did not address Resident #84's active diagnosis of Heart Failure.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation and interviews, the facility failed to revise the care plan for 1 resident (Resident #3) and failed to provide resident and resident representative notice of quarterly care plan conferences for 1 resident (Resident #105) of 26 residents reviewed for care plans. The findings include:Review of the facility's policy titled, Baseline Care Plan Assessment/Comprehensive Care Plans, revised 3/23/2021, revealed .The facility Social Service Director or designee will notify the resident's responsible party either by letter or a phone call to inform them of the scheduled Care Plan Conference to include the date and time .these notifications will be documented for reference .An IDT [Interdisciplinary Team] note will be made in reference to the meeting to include who attended, significant changes addressed and date and time of the meeting .Review of the facility's policy titled, Care Plans, dated 8/2022, revealed .Care Plans will be updated as changes occur. New problems will be added as they occur as well as resolved when the problem is no longer a problem for the resident . Review of the Medical Record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Chronic Kidney Disease Stage 5, Dependence on Renal Dialysis, Presence of Vascular Implants and Grafts.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #3 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment indicating the resident was cognitively intact and received dialysis. Review of the Physician Progress Note for Resident #3 dated 1/12/2026, revealed .remove Perma Cath [catheter placed for short term dialysis treatment] and place AV fistula [a surgically created connection between an artery and a vein for hemodialysis] . Further review revealed the Perma Cath is scheduled to be removed on 1/22/2026. Review of a comprehensive care plan for Resident #3 dated 1/13/2026, revealed the care plan had not been revised to include the Perma Cath.During an observation on 1/12/2026 at 1:30 PM, revealed Resident #3 had a Perma Cath in place to the right chest. During an interview on 1/13/2026 at 4:35 PM, the Licensed Practical Nurse MDS Coordinator confirmed Resident #3's care plan did not reflect the presence of a right chest Perma Cath or interventions. During an interview on 1/14/2026 at 4:00 PM, the Regional Registered Nurse confirmed the care plan had not been updated to reflect the Perma Cath. Review of the medical record revealed Resident #105 was admitted to the facility on [DATE], with diagnoses including Congestive Heart Failure, Dementia, and Anemia. Review of the medical record revealed a care plan meeting progress note dated 3/24/2024, revealed the interdisciplinary team reviewed medications, diet, and activities. Further review revealed the resident representative was invited to attend the meeting. Continued review revealed no documentation of additional care plan meeting since 3/24/2024. During an interview on 1/13/2026 at 8:49 AM, Resident #105's daughter stated .the family would like more involvement in care planning of mom's care . During an interview on 1/14/2026 at 8:25 AM, the Social Services Director stated she was unable to locate quarterly care plan meeting notes for Resident #105.During an interview on 1/14/2026 at 9:20 AM, the Regional Registered Nurse confirmed there were no quarterly care plan meeting notes/documentation or invitations since 3/18/2024 for Resident #105.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observations, and interview the facility failed to ensure medications were secured in 1 resident (Resident #43's) room of 115 resident rooms observed.The findings include: Review of the facility Policy titled, Medication Self Administration, undated, revealed .Policy .Residents who request to self-administer drugs will be assessed at the time of admission or thereafter to determine if the practice is safe, based on the results of the Resident Assessment Self-administration Tool .The assessment results will be discussed with the attending physician and an order obtained to self-administer if appropriate . Review of the medical record revealed Resident #43 was admitted to the facility on [DATE] with diagnoses including Dementia, Major Depressive Disorder, and Metabolic Encephalopathy. Review of a PPS (Prospective Payment System) Part A discharge Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #43 scored a 6 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Review of the Physician's Orders for Resident #43 revealed the resident had no order to self-administer medications. During an observation in Resident #43's room on 1/12/2026 at 12:54 PM, revealed a 0.5 fluid ounce of liquid tear eye drops (medication used to treat dry eyes) on the bedside table, a bottle of extra strength 125 mg (milligram) gas relief tablets, and a bottle of antacid chews 750 mg (medication used to treat heartburn) on the bathroom sink. Further observation revealed a bottle of antifungal powder miconazole nitrate 2% (percent) (medication used to treat skin infections) in the window seal. During an observation and interview in Resident #43's room on 1/13/2026 with Registered Nurse (RN) A at 10:45 AM, revealed a 0.5 fluid ounce of liquid tear eye drops on the bedside table, a bottle of extra strength 125 mg gas relief tablets, and a bottle of antacid chews 750 mg on the bathroom sink. Further observation revealed a bottle of antifungal powder miconazole nitrate 2% in the window seal. RN A stated Resident #43 did not self-administer medications and confirmed the medications were unsecured in the resident's room.

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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 facility policy review, medical record review, observation, and interviews the facility failed to follow Enhanced Barrier Precautions (EBPs) for 1 resident (Resident #15) of 22 residents reviewed for EBPs. The findings include: Review of the facility policy titled, .GUIDELINES for ENHANCED BARRIER PRECAUTIONS---[Enhanced Barrier Precautions] (EPBs), dated 12/2022, revealed .An extension of Personal Protective Equipment---[Personal Protective Equipment] (PPE) .It is the policy of the facility to ensure that additional and appropriate PPE .is utilized .to prevent the spread of Multidrug-resistant Organisms also known as MDRO .Examples of High Contact Resident Care Activities at which time EBP is to be practiced are .Changing Briefs .Resident Care Activities with a resident who has a known MDRO [bacteria resistant to multiple antibiotics making infections difficult to treat] .use .gloves and gowns . Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Dementia, Type 2 Diabetes, Major Depressive Disorder, and Anxiety Disorder. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #15 scored a 7 on the Brief Interview for Mental Status which indicated the resident had moderate cognitive impairment and was always incontinent of urine and bowel. Review of the Physician's Order for Resident #15 dated 12/1/2025, revealed .Enhanced Barrier Precautions .[Multi Dose Resistant Organism] MDRO . During an observation on 1/13/2025 at 5:24 AM, revealed Resident #15's entrance way door had an EBP precaution sign posted which stated .PROVIDERS AND STAFF MUST .Wear gloves and gown for the following High-Contact Resident Care Activities .Changing briefs . Further observation revealed Certified Nursing Assistant (CNA) E entered the room, applied gloves, did not apply a gown, provided incontinence care to the resident (changed brief), removed the gloves, exited the room, and sanitized the hands. During an interview on 1/13/2025 at 5:33 AM, CNA E stated .I didn't realize she [Resident #15] had a sign [EBP] .I feel like the signs are old . CNA E confirmed she did not wear a gown when she changed Resident #15's brief. During an interview on 1/13/2025 at 8:19 AM, the Assistant Director of Nursing stated when a resident was on EBP's staff were expected to wear a gown when providing incontinent care including changing briefs. The ADON confirmed CNA E failed to follow the facilities infection control policy when she failed to wear a gown during incontinence care for Resident #15.